The Modern Hospital

JULY 1954

Symposium on the Professional Activity Study of the Southwestern Michigan Hospital Council • The Case of Dr. Lloyd Mousel • Clinical Pathological Conferences in the Small Hospital • Community Relations • How to Train Supervisors

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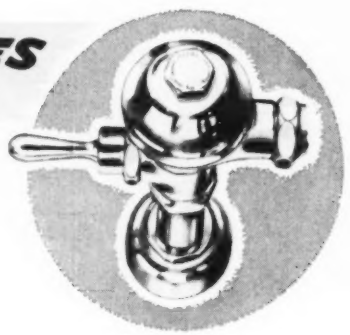

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The Modern Hospital

JULY 1954

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AMONG THE AUTHORS


John H. Gorby

John H. Gorby, administrator of La Mesa Community Hospital, La Mesa, Calif., has been an active leader in the development of the successful community hospital section of the Association of Western Hospitals. The article on page 94, describing a program of clinical pathological conferences for a group of small hospitals, is an outgrowth of one of many lectures Mr. Gorby has developed for community hospital institutes sponsored by the association. A graduate of the University of California at Los Angeles, Mr. Gorby was a public accountant in California for 15 years, specializing in hospital practice, before he became a hospital administrator. He has been a director of the Southern California Hospital Council and president of the Hospital Council of San Diego County, and is still active as a consultant to hospitals on finance and accounting problems.


Edmund Mottershead

Edmund Mottershead, whose article on supervisory training appears on page 72, is a personnel consultant in Chicago whose previous articles in The Modern Hospital on personnel problems have been widely popular with readers. Mr. Mottershead has been a member of the faculty of New York University and Loyola University, Chicago, and has lectured to business groups on personnel, public relations, and other management problems. He is author of a number of articles on these subjects that have appeared in the business press.


Margaret Dykes

Margaret Dykes, dietary consultant for the division of hospital services of the Georgia Department of Public Health, whose program is described in the article beginning on page 114, received her degree in home economics from Alabama Polytechnic Institute. Following her graduation, she was a member of the dietary staff of the institute, serving as head dietitian in 1944 and 1945. She received a master's degree in foods and institutional management at the University of Tennessee in 1946, following which she had teaching positions at the Tennessee Polytechnic Institute and at the University of Georgia. For two years, she was resident manager of Tapoco Lodge at Tapoco, N.C. Miss Dykes is currently president of the Georgia Dietetic Association and the Southeastern Hospital Conference of Dietitians. She had the major responsibility for preparing and editing the hospital diet manual recently issued by the Georgia Department of Public Health.


Ernest P. Ribet

Ernest P. Ribet is vice president of the board of directors and chairman of public relations for the Ohio Valley General Hospital at McKees Rocks, Pa., whose community relations program is described in the article on page 81. Mr. Ribet is sales manager for the mid-eastern district of the Gerrard Steel Strapping Division, U. S. Steel Corporation, at McKees Rocks. He has been associated with U. S. Steel for 35 years. Active in civic affairs in McKees Rocks for a number of years, Mr. Ribet served as general chairman of one of the hospital's major capital fund campaigns, and he has assumed key responsibilities in all its public appeals and activities. He is convinced that the general hospital today must employ the same public relations technics that are used successfully in business and industry.

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1. BOYD, A. M.: FLETCHER, F., and RATCLIFFE, A. H.: Supportive Therapy. An Improved Type of Dextran, *Lancet, Jan. 10, 1953, p. 59.*

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Roving Reporter

My Trip to Australia

By MALCOLM T. MacEACHERN, M.D.

It is my wish that all our people could visit Australia, as we did, for a better appreciation of the joy of living. True, it is Down Under a long way from home, but it is a marvelous country and the people are grand. It is the spirit of the Australians and their attitude toward life and living that really make a great empire.

An invitation to visit Australia originated with the Federal Council of the Australian Hospital Association and was supported by the governments of Australia and the states of New South Wales and Victoria. It had the good will and cooperation of many official and nonofficial agencies, organizations and individuals interested in health, hospitals and medical education.

The purposes of my visit were, first, to examine the teaching hospitals, or clinical schools, as they are called, and, second, to advise on any problems affecting the care of the sick and injured in hospitals throughout Australia, as far as time would permit.

I was accompanied on the trip by my daughter, Isobel, and by William Calvin, a graduate of the program in hospital administration at Northwestern University, and currently assistant director of Muhlenberg Hospital, Plainfield, N. J. Mr. Calvin assisted me in the survey and studied hospital and related activities in Australia.

When I went to Australia in 1925-26, it took me 23 days by boat. Last fall we flew there from Chicago, in 36 hours, about 27 hours of which were over the ocean. The trip both ways was pleasant.

We traveled approximately 30,000 miles in all, of which 1200 miles were by automobile and 250 miles by train. We visited the states of New South Wales, Victoria, South Australia, West Australia, and the Australian Capitol Territory where Canberra, the seat of the federal government, is located. We did not have time to visit the three remaining subdivisions, Queensland, Tasmania and the Northern Territory.

The change in time confused us a little. After we passed the international date line, we dropped a day, Tuesday, October 13, and landed in Sydney on Wednesday, October 14. Returning, we picked up a day and landed in Honolulu the same date we left Australia, Thursday, December 3.

Arriving at the airport in Sydney, we had a grand welcome from government officials, hospital representatives, and other organization officials and friends, and were driven to the Royal Prince Alfred Hospital, an outstanding institution, where we were housed in a suite consisting of a spacious office and parlor, and three bedrooms. This suite was our headquarters for the greater part of our stay in Australia. We were much impressed by the comfort, convenience and pleasantness of our accommodations, and I feel that all large hospitals should provide such unique quarters for guests. The fine hospitality of officials and staff of the hospital was unsurpassed and every facility was provided to assist us.

When I was in Australia in 1925-26, I made many recommendations affecting hospitals and care of patients. Some involved more or less radical changes. It was gratifying to observe that most of these were in effect.

One of the major recommendations was the provision of semiprivate or intermediate and private room accommodations for pay patients in the larger hospitals. This is now a generally accepted practice when building new hospitals.

Also recommended was the multistoried hospital, instead of the pavilion type, and this has been generally adopted. I encouraged the formation of hospital districts, with a base hospital in each district and the smaller hospitals depending on it for major services. This development has been most successful.

The practice of medicine and hospital care are not nationalized in Australia, as some people believe. The physician follows the independent practice of medicine unless he desires to go into government service. We found much voluntary effort in the various states visited. In the city of Melbourne and other parts of Australia, we observed that financial campaigns were being conducted for hospitals, such as we have here. It was interesting to see voluntary effort in the form of endowments, benefactions, donations, gifts and memorials throughout Australia.

Generally speaking, we sensed a good deal of opposition to nationalization of medicine and hospitals but much favor toward cooperation of government and voluntary interests in the care of the sick and injured. Much interest was manifest in our Hill-Burton plan.

The medical profession of Australia on the whole is well qualified through graduate and postgraduate education and additional qualifying degrees. Much attention is now given to well trained hospital administrators. Formal training in hospital administration is encouraged. An Institute for Hospital Administrators carries on a much needed extension course.

During our seven weeks in Australia, we followed a detailed and well documented schedule occupying every hour of our day and evening. Apart from the work assignments, there were receptions, luncheons, dinners, meetings and entertainment. A few highlights of my work and study may be of interest:

One of the most serious situations in Australia is lack of teaching accommodations and facilities in hospitals or clinical schools for medical students.

Australia's four medical schools are located in Sydney, Melbourne, Adelaide and Brisbane. There are 11 parent, or basic teaching, hospitals, and 13 ancillary, or affiliated, hospitals, for the teaching of certain specialties.

The medical student spends six years acquiring his degree, the first three in medical school and the final three in a teaching hospital.

During his last three years, the medical student comes in contact with another teaching staff for his clinical work and the teaching hospital has the responsibility of completing his education for a degree in medicine.

There is no restriction on the number of students who enter the first year of medicine, other than a preliminary examination. Generally speaking, the load on all hospitals is far beyond the capacity of teaching facilities. In one hospital 335 students are enrolled.

There is noticeable interest in Australia in the medical center idea, par-

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ticularly in connection with teaching hospitals. The Royal Prince Alfred Hospital in Sydney is developing fast in this regard. The proposed expansion program will greatly accentuate this feature. The new Medical Center in Melbourne is developing rapidly.

It is believed, as in our country, that the day of the special hospital standing independently has passed because of increased costs in maintaining overhead and duplication of facilities and services. The teaching hospitals in Australia should follow, as far as possible, the medical center idea in carrying out their educational responsibilities.

It is expected the entire problem of medical education will be studied by a national Commission on Medical Education and Teaching Hospitals with a fact-finding committee to make a detailed analysis of the functioning organization and physical needs. No doubt beneficial results will come from its report.

The present plan of financing Australian hospitals is unique. Before 1946, Australian hospitals were financed from patients' fees, which fell far short of the cost of care, and from subsidies from the states to make up the deficit. Hospital services were regarded as a state responsibility. In 1946, Labor Prime Minister Chifley entered the hospital financing field and offered to pay 6 shillings per patient day to hospitals, if hospitals would not charge inpatients for public hospital beds. (Inpatients were not subject to a means test, while outpatients were.) The amount was later increased to 8 shillings because of rising costs.

Then in 1949, there was a change in the Australian government and Mr. Menzies of the Liberal party succeeded Prime Minister Chifley. Sir Earle Page came into office as Minister for Health. Sir Earle concluded that although more money was needed for financing hospitals, the only sources were increased taxes and a charge for public ward patients, which would not be desirable. Therefore, he reintroduced the means test for inpatients.

In order to encourage voluntary health insurance and to give the public an incentive to participate in that type of health coverage, Sir Earle offered to pay 12 shillings per patient day toward hospital charges for every patient who belonged to a voluntary insurance plan. The additional cost to the federal government was to be offset by the greater number of persons joining the insurance plan. In this way, hospitals would be assured that most of the patients' bills, after the government's subsidy payment, would be met by insurance plans. At the same time, the increased income from the plans would relieve the state and federal government of the responsibility of providing still greater financial subsidies to hospitals.

The main hospital insurance plan of New South Wales is the Hospital Contribution Fund of New South Wales, a voluntary, nonprofit concern. Each state has various plans but all are regulated by the Blue Cross Association of Australia.

Regardless of whether or not the hospital is a teaching institution, money from the federal government and the insurance plans is paid on an equal basis. The expense of teaching, an extra burden on the hospital, is not shared by the federal government, although the state government assists in making up any deficit the teaching institution incurs. It is felt the federal government should bear more of the teaching hospital's burden because physicians trained by these hospitals go to all states to practice their profession.

For the first time in their history some hospitals did not have a deficit last year. In fact, some had a surplus. The plan, owing to the foresight and leadership of Sir Earle Page, is most commendable and is working out successfully. It is a good illustration of government and voluntary effort working hand in hand. The names of vanSteenwyk and McNary of the United States were frequently mentioned in connection with the valuable advice they rendered during their visit to Australia last year. They consulted with Sir Earle Page on the voluntary health insurance plan.

The financing of capital expenditure is a different matter. When hospitals desire money mainly to finance new construction or to rehabilitate old structures, they make their need known to the hospital commission or the proper authority of the state.

The federal government is the only taxing body in Australia. All state governments submit budgets to the federal government outlining their needs and requirements. State representatives get together and decide on the division of these funds among the states, usually on a population basis. After allotments have been made, the states designate various amounts for certain purposes, one of which is cap-

ital expenditures for hospitals. The money is then turned over to the hospitals, according to recommendations of the state hospital commission or proper authority, and individual hospitals use their respective allocations for the purposes specified. There is some local effort to raise money for capital purposes but it is becoming less and less.

At present there is urgent need for a special appropriation of a sizable amount for new construction, additions or rehabilitation of teaching hospitals associated with the four medical schools. Most of the money appropriated annually has been to replace or rehabilitate rural hospitals. While in no way discounting the splendid work of the Hospital Commission of New South Wales and the Hospital and Charities Commission of Victoria, we must not overlook the urgent need for adequate teaching facilities in maintaining the standard of medical education desired in Australia.

Rural hospitals in Australia are generally well organized and managed. When there in 1925-26, I gave special attention to a study of the classification of hospitals, based on facilities, personnel and equipment; in other words, what work they could undertake with safety to the patient. The classification involved metropolitan, base, district and cottage hospitals, and bush nursing centers. It was gratifying to observe development in this respect since my visit 27 years ago. In each district, there is a base hospital or one up to full strength, on which other hospitals within the district are dependent for major services.

My recommendation is that the trustees and the executive and supervisory personnel of the hospitals within the district confer regularly on local problems and that they carry on an educational program. I would also recommend that members of the administrative and supervisory staff of the base hospital, such as the administrator, director of nursing service, dietitian, medical record librarian and others, visit the smaller hospitals and help them with their problems. Nurses in training should have a tour of duty in the more rural hospitals of the district. Ambulance services in each of the states visited are well organized and efficiently operated on a statewide basis, centrally controlled and maintained, mostly through voluntary contributions, fees from patients, and sometimes state subsidy.

Ambulance services are strategically located so that no ambulance has to travel more than 40 or 50 miles. These vehicles, well equipped and maintained, are staffed with competent drivers and first-aid personnel.

The visitor is impressed with evidence of good nursing care when making rounds in the wards of Australian hospitals. He will notice particularly the cleanliness and wholesome atmosphere of the wards. There appears to be an adequate number of nurses under competent supervision for bedside care. Working and living conditions are good and conducive to nursing as a career. Usually each nurse has a room to herself in a fine residence on the hospital grounds.

The training of nurses generally is on a three-year basis, except in New South Wales, where it takes four years. Throughout Australia, the nurse must spend an additional year in training if she desires to do obstetrics.

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(*Continued on Page* 136)

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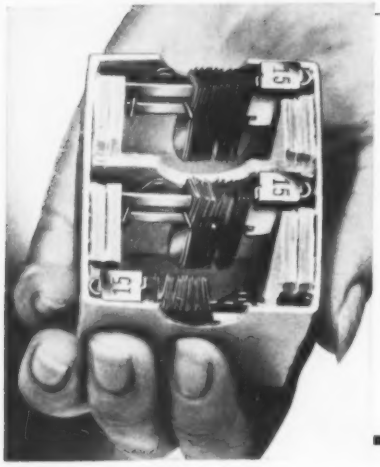

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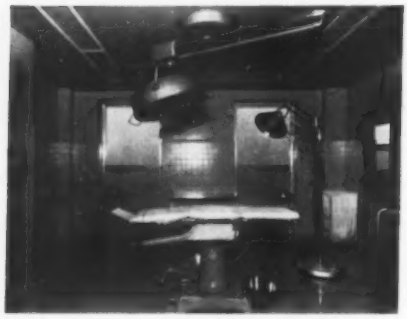

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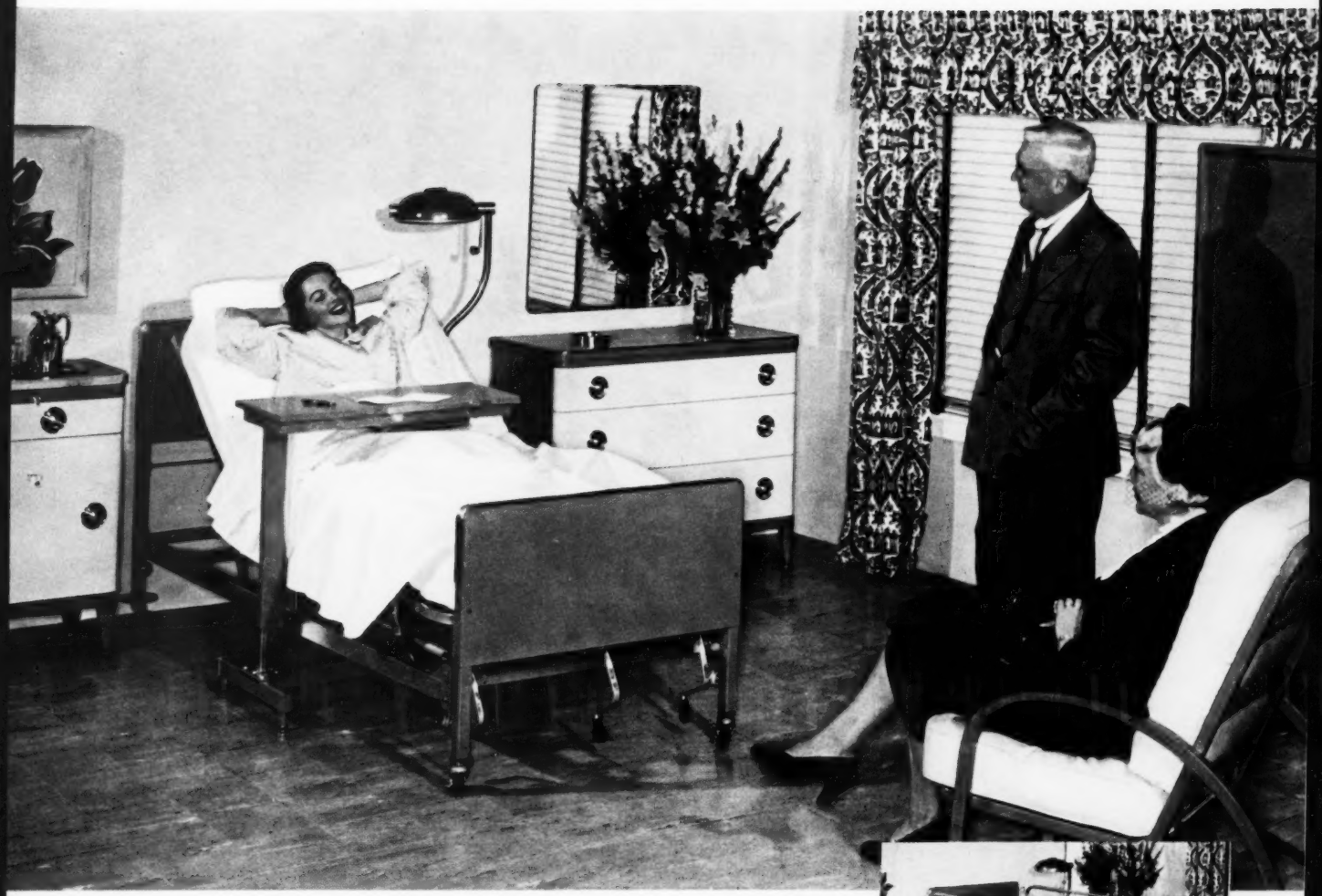

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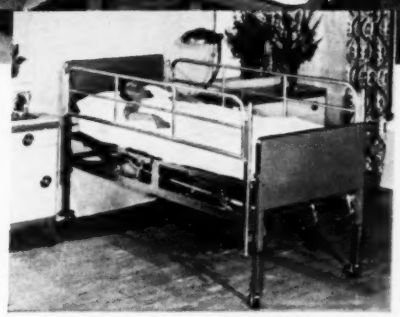

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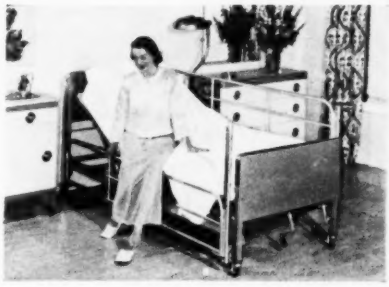

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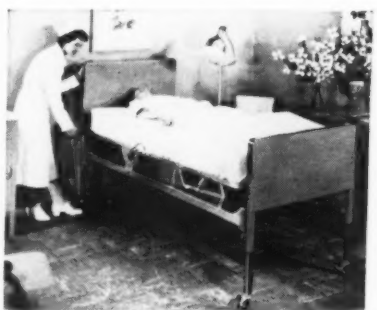

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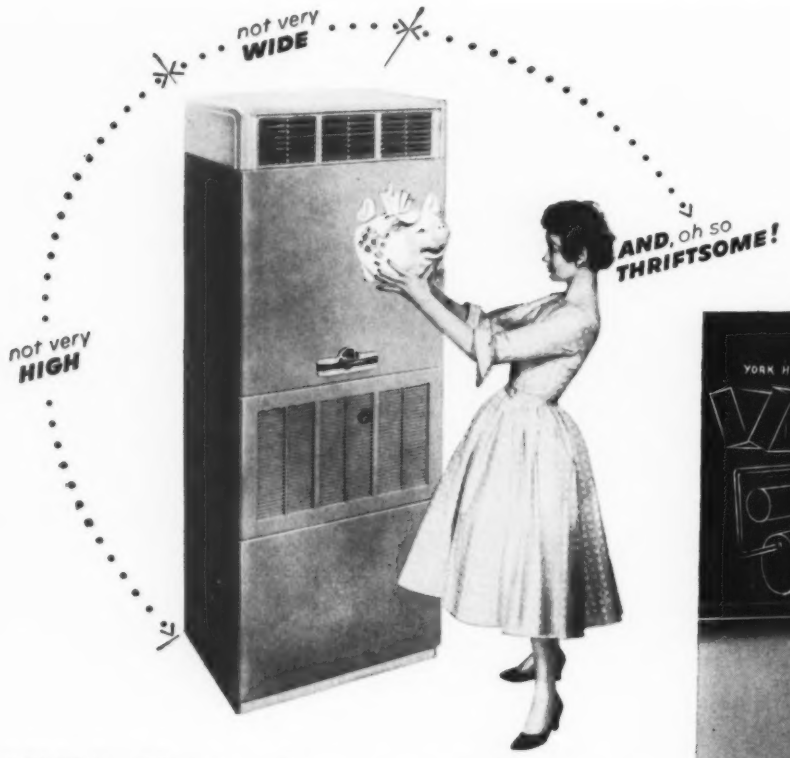
It pays to **ANALYZE** your flooring plans

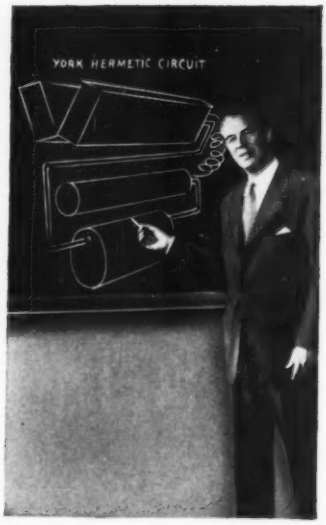
ASK YOURSELF: what are the major features flooring material should combine? Beauty and luster are essential, of course...and there should be a large selection of colors and patterns. Long wear and easy cleanability are vital. These two go together . . . to keep up the beauty . . . to keep down the cost. And don't forget resiliency for foot comfort, and ease of installation.

How many types of flooring offer *all* these benefits? No matter how many you consider, *only one type provides every fundamental requirement to a high degree.* Flooring "made of BAKELITE Vinyl Resins" is your sure and simple specification. It stands for highest quality in the resins that bring you so many flooring advantages. No other type of flooring provides so much.

BAKELITE
TRADE-MARK
VINYL RESINS
TRADE MARK

BAKELITE COMPANY, *A Division of Union Carbide and Carbon Corporation* UCC 30 East 42nd Street, New York 17, N. Y.

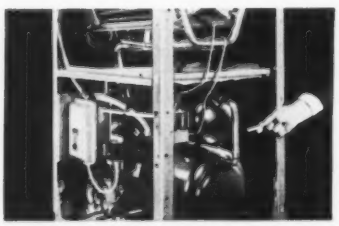




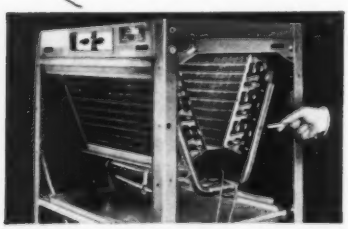
New 1954 Yorkaire conditioner can pay for itself seven times over by 1964!

In addition to increasing the efficiency of your personnel (an important cost-saving factor) York eliminates expensive fall "shut-down" and spring "start-up." Entire cooling circuit is hermetically sealed. Dirt and moisture can't leak in, costly refrigerant can't leak out.

Double comfort—2 systems for the price of 1! When "it's the humidity, not the heat," just flip the York Atmostat switch! An automatic valve goes right to work. All the refrigerant is concentrated in half of the cooling coil (above) to wring excess moisture from the air *without* excess cooling.



Dependable—5-Year Protection Plan can save you hundreds of dollars. If the hermetically sealed cooling circuit proves defective in any way because of faulty materials or workmanship, York will repair the defective part or replace the entire cooling circuit without cost!



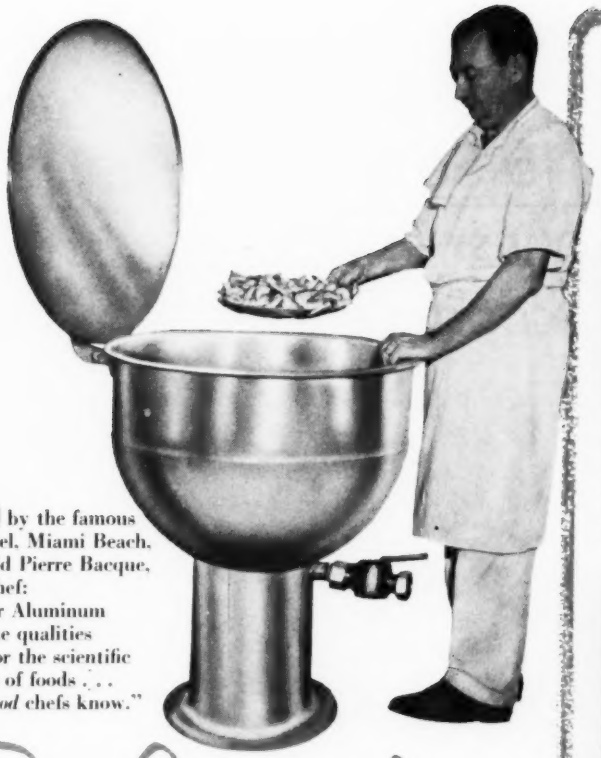
Efficient—30% more effective cooling results from patented staggered-tube-and-corrugated-fin construction that tumbles *all* the air into contact with cooling surfaces. York's "V-Coil" reduces air resistance, thus allows lower fan motor horsepower. And York is Underwriters' Laboratories approved.

air conditioning by york

In homes and offices, ships and stores, skyscrapers, factories, hospitals, theaters . . . almost everywhere you go, when the air conditioning is just right, chances are it's York Air Conditioning. Your York Distributor will be happy to consult with you and calculate your air conditioning needs. He can fill your requirements with precision, because he handles a wide range of Yorkaire Conditioners. He's listed in your Classified Telephone Directory. Call him soon!

YORK CORPORATION York YORK, PA.

HEADQUARTERS FOR MECHANICAL COOLING SINCE 1885



PREFERRED by the famous Algiers Hotel, Miami Beach, Florida. Said Pierre Bacque, executive chef: "Wear-Ever Aluminum possesses the qualities necessary for the scientific preparation of foods . . . a fact all *good* chefs know."

Preferred...

BECAUSE THEY COOK SO MANY THINGS . . . SO WELL

Whether you're preparing vegetables, meats, or poultry . . . soups, combination dishes or cereals . . . fruits, puddings or pie fillings . . . sauces or syrups . . . you can be *sure* of fine results with Wear-Ever Aluminum Steam Jacketed Kettles.

The secret is in the aluminum alloy. It conducts the heat into the food *quickly and evenly!* And when the heat is turned off, cooking stops almost immediately, eliminating the possibility of *over* cooking, giving greater control.

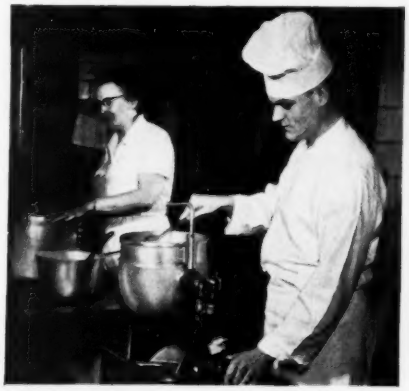
With Wear-Ever aluminum kettles, you can use lower steam pressure. You have a kettle that is COMPLETELY sanitary. And it's made from a newer, stronger aluminum alloy, with almost twice the strength of the one formerly used.

Available in tubular, pedestal and trunnion styles from 10 to 150 gals. Also available in table top trunnion in 2½ and 5 gal. capacities. The Aluminum Cooking Utensil Co., Inc., Dept. 707, New Kensington, Pennsylvania.

WEAR-EVER *Aluminum*

Standard of Quality WEAR-EVER ALUMINUM TRADE MARK REG U.S. PAT OFF. for more than 50 years

PREFERRED by the Cedars of Lebanon Hospital in Los Angeles, California. They wanted the finest, specified Wear-Ever Aluminum steam jacketed kettles.



PREFERRED by Cornell University Hotel Management School where Wear-Ever Aluminum is among the equipment used in training the hotel executives of tomorrow.

PREFERRED and specified in the glamorous kitchens of the new Toffenetti Restaurant in the Greyhound Terminal, Chicago, Illinois.

Looking for Some new ways to Save on expensive condiments?

You may find Dixie Cream, Condiment and Restaurant Cups mighty helpful.
There's a size for every need! With Dixie Cups—you can pre-portion *exactly!*
No waste of expensive items like cream, dressings, and jam. And
pre-portioning will save you time when lots of trays have to be handled.
Dixie Cups save time and money in other ways. They are used but once,
then thrown away. They are light, store easily, reduce mealtime noise.
Why not have a talk with your Dixie Cup Distributor sometime soon?

REMEMBER—
WHATEVER YOU SERVE...
WHEREVER YOU SERVE—
THERE'S A DIXIE CUP FOR YOUR FEEDING NEEDS!

DIXIE FOOD DISHES
for ice cream, salads, puddings and fruit.

PAC-KUP FOOD CONTAINERS
for soups, stews and main dishes. Tight fitting lids keep foods hot.

DIXIE COLD DRINK CUPS
for water, fruit and vegetable juices, milk and soft drinks.

DIXIE HOT DRINK CUPS
in a variety of sizes for coffee, tea, cocoa.

"Dixie" is a registered trade mark of the Dixie Cup Company.

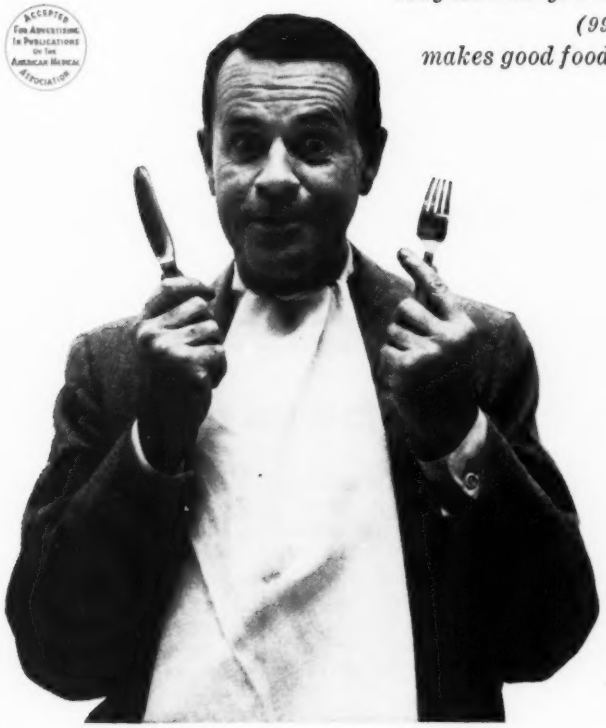
Dixie Cups

DIXIE CUP COMPANY Easton, Pa., Chicago, Ill., Darlington, S. C., Ft. Smith, Ark., Anaheim, Calif., Brampton, Ont., Canada

Here's a way to make patients on diets ...sing for their supper

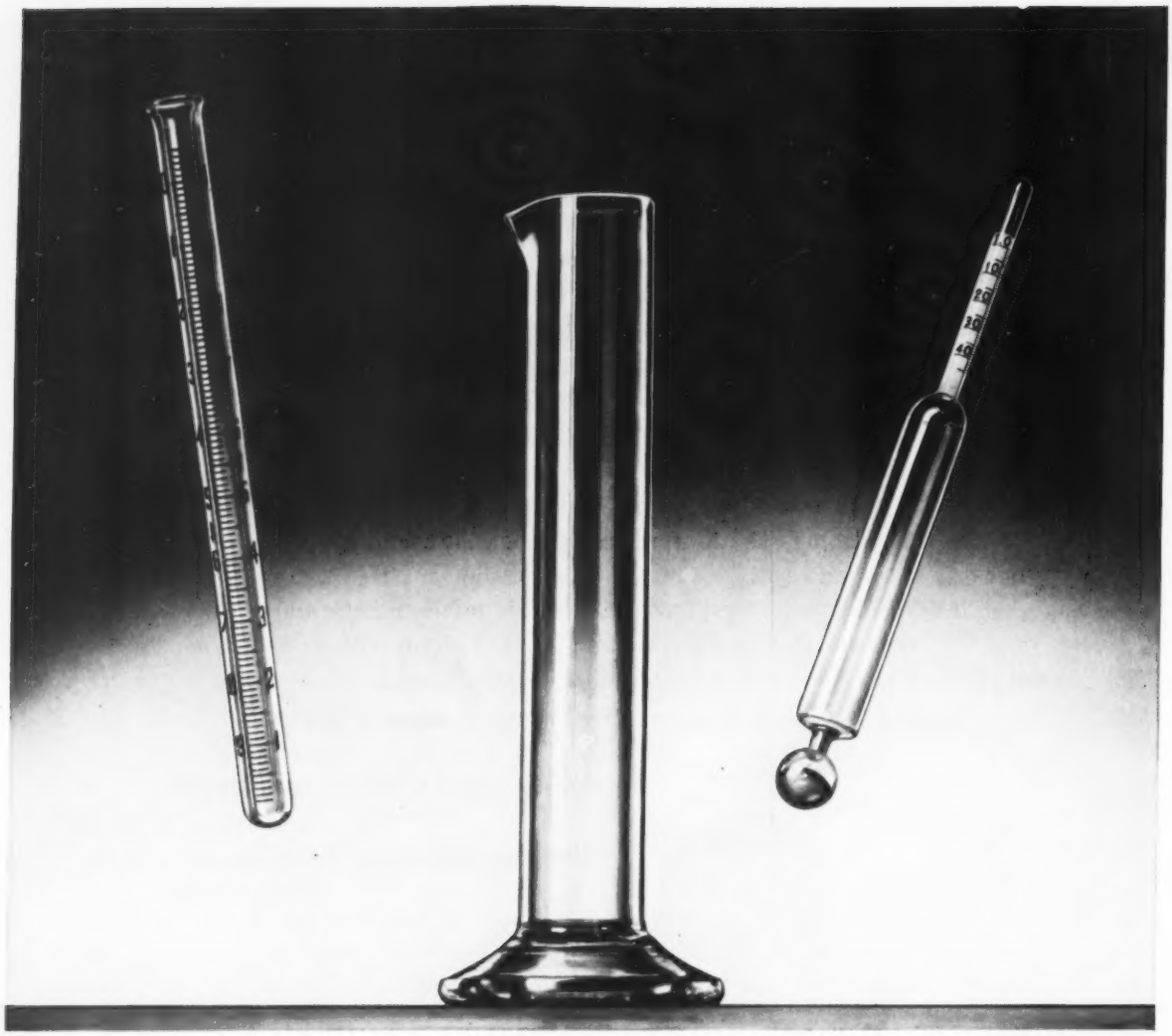
No patient likes being on a diet . . . but it certainly helps — more than anything else you can recommend — to suggest the use of Ac'cent in making food more naturally flavorful and enjoyable. Ac'cent offers a superb way of adding taste to diet food simply by bringing out the *natural* flavors of foods. So amazing is this flavor-enhancing protein derivative (99+% pure monosodium glutamate) that it even retains the true delicious flavors in foods that must be held for a long time before serving. Flavorful food means food that will be eaten . . . recommend Ac'cent not only in your special diets where indicated but to "finicky" eaters and all others who never get enough nutritious foods. Ac'cent is derived from natural food sources. It is not a synthetic and it is nontoxic. Its sodium content is only 12.3 per cent. Ac'cent is not a salt substitute, but it will make foods more flavorful. Best of all, Ac'cent is easily obtainable by your patient at neighborhood food stores.

May we send you a brochure on **Ac'cent®**
(99+% pure monosodium glutamate)
makes good food and good cooking taste better!



AC'CENT, T.M. Reg. U. S. Pat. Off.

AMINO PRODUCTS DIVISION International Minerals & Chemical Corporation
20 North Wacker Drive • Chicago 6, Illinois



Shown here in actual size are Kimble Hematocrit Tube #46749, Glasco SMALL Urinometer Set #765.

Announcing

two NEW Glasco laboratory items

KIMBLE HEMATOCRIT TUBES:
You'll never worry about "losing" the calibrations on these new Hematocrit tubes. Kimble uses a "color filler" that is as resistant to chemical attack as the glass itself. Graduated scales will never become illegible, regardless of the way the tubes are washed or handled.

GLASCO SMALL URINOMETERS:
Now you can use as little as 15 ml. of urine with complete test accuracy. The heavy glass foot of the cylinder is accurately leveled by grinding and insures against easy tipping. The mercury-filled hydrometer is retested to allow a maximum tolerance of plus or minus .002 specific gravity. It remains stable and upright even in solutions where specific gravity is close to 1.000.

Every Hematocrit tube and urinometer is individually tested and retested to be sure of its accuracy. All are thoroughly annealed to increase mechanical strength.

There is a Glasco item for every laboratory requirement. Order from your hospital supply house, or write direct to us for a free copy of our latest catalog and price listing.

GLASCO PRODUCTS CO.

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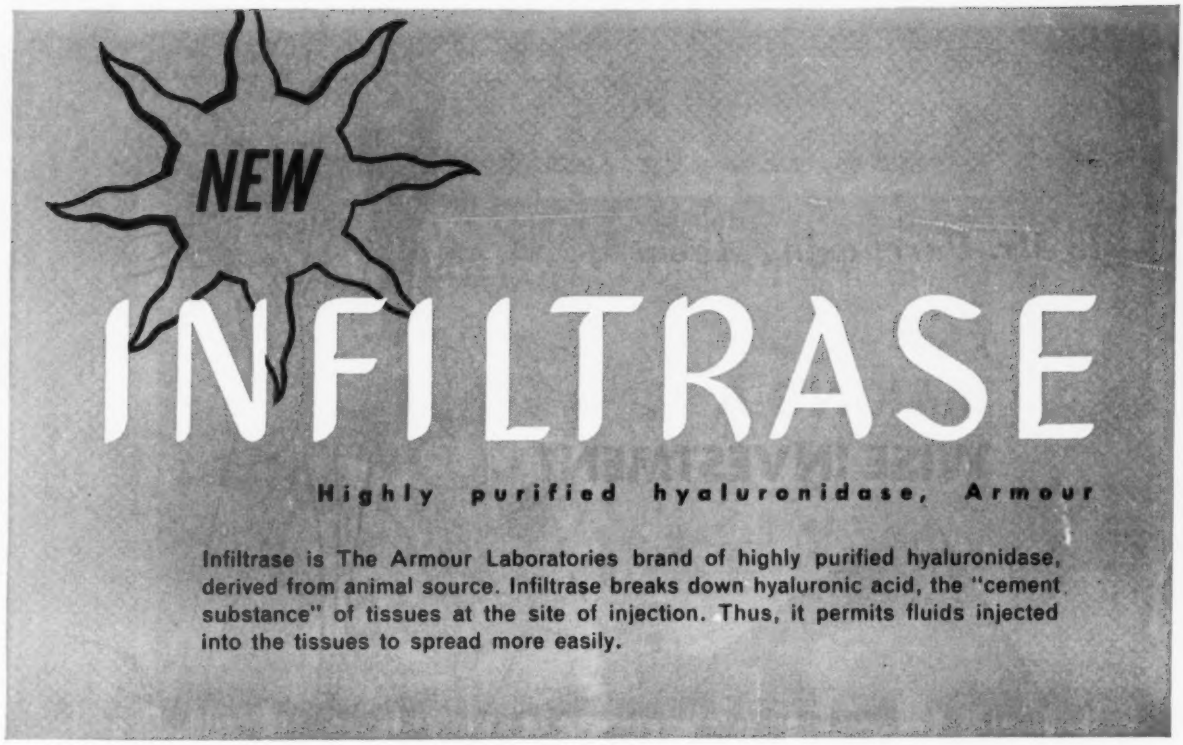


INFILTRASE OFFERS THESE HIGHLY SIGNIFICANT ADVANTAGES . . .

- facilitates subcutaneous administration of fluids
- permits rapid infiltration of local anesthetics
- enhances the action of the pudendal block
- in renal lithiasis, is credited with preventing new stone formation, and preventing an increase in the size of existing stones
- safety
- easy to administer . . . no intricate setup required

INFILTRASE is supplied as a lyophilized powder in 1 cc. vials containing 150 TR (turbidity reducing) units, and 10 cc. vials, containing 1500 TR units.

THE ARMOUR LABORATORIES
A DIVISION OF ARMOUR AND COMPANY • CHICAGO 11, ILLINOIS

to Mr. Purchasing Agent

FOR MAKING A WISE INVESTMENT

he switched to

ANGELICA "SAFETY-LOK"* SURGEON GOWNS

and needed fewer replacements

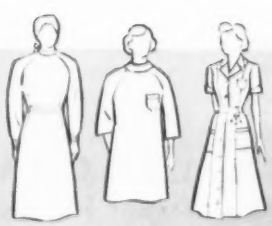
A farsighted P. A. can invest in the future — and come out with real savings. Hundreds have switched to Angelica "Safety-Lok" Surgeon Gowns and found Angelica's extra durability pays off in good hard cash. Look at these features:

(1) Exclusive "Safety-Lok" flap eliminates ties and provides comfortable fit. (2) Replacement of ties with indestructible cloth buttons reduces linen room repair costs. (3) Overlap in back provides complete sterility. (4) Durable re-inforced front yoke. (5) Raglan sleeves. (6) Permanently elastic, absorbent double-stockinette cuffs. (7) 54-inch finished length. (8) Tunnel belt — no loss, no repairs.

All Angelica Hospital Apparel is available for immediate delivery. Call your Angelica representative today.

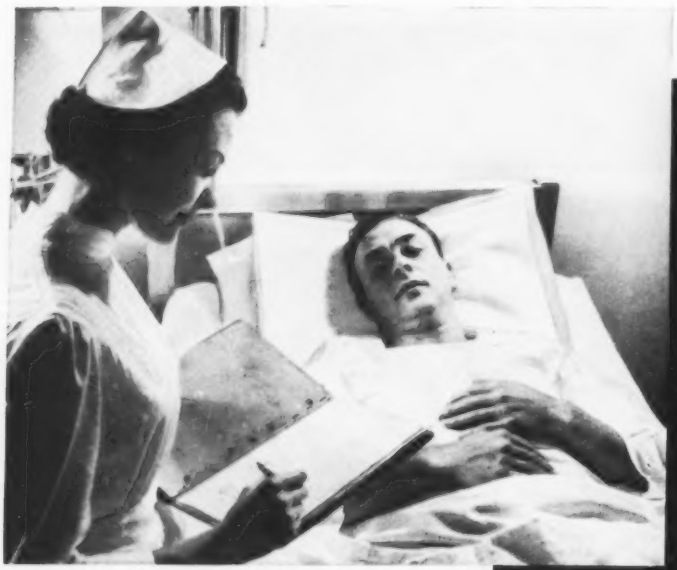
*T. M. Reg.

Complete Line of Uniforms for:
DIETARY
MAINTENANCE
OPERATING ROOM
HOUSEKEEPING
PATIENTS
NURSING

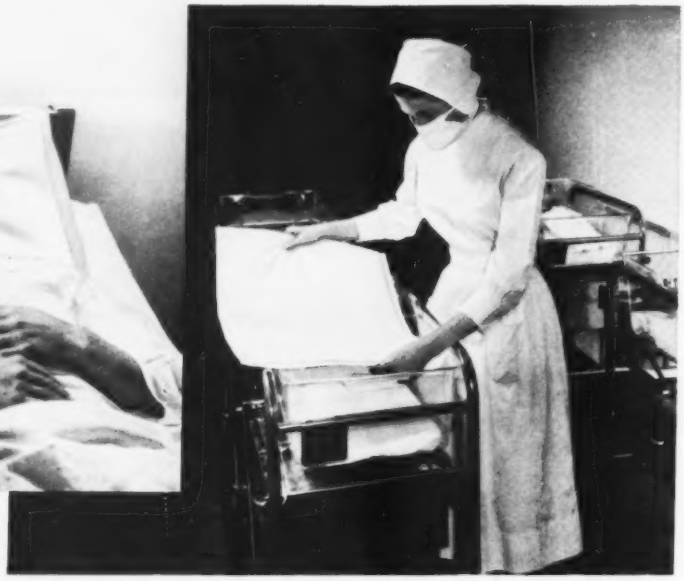


Angelica® UNIFORMS

1427 Olive, St. Louis 3 • 107 W. 48th, New York 36 • 177 N. Michigan, Chicago 1 • 110 W. 11th, Los Angeles 15



***CURITY* INCONTINENT PAD** is finest underpad made, gives you top value.



NEW *CURITY* WARD PAD is priced low, yet has many top-quality features.

Your 2 Best Buys in Underpads...

WHICH IS BETTER FOR YOUR HOSPITAL?

1.

BEST PAD THAT MONEY CAN BUY

- Completely waterproof pad means less-frequent changes, fewer pads per patient, greatest linen protection.
- Cover sheet is remarkably soft, yet extra strong —wet or dry. Has comfortable, soft-as-skin feel.
- Cover sheet transfers drainage immediately, is more tear-resistant than regular top sheets.
- Filler is 10 full plies of genuine Cellucotton* . . . is thicker and holds more drainage than ordinary underpads.
- Plastic bottom sheet with heat-sealed edges makes pad 100% leakproof. In test, pad held water 7 days with no sign of leakage, while moisture penetrated ordinary paper-backed pads in a short time.
- Plastic bottom sheet has "non-slip" traction . . . no paper crackle.

Curity
REG. U.S. PAT. OFF.

INCONTINENT PAD

2.

BEST PAD IN LOW-PRICE FIELD

- Cover sheet is soft, strong wet or dry, lint free. Transfers drainage quickly to filler.
- The only low-priced pad with genuine Cellucotton* filler, the most absorbent filler material available.
- Filler is 6½ plies (7 plies in center), holds more fluid than comparable pads. No open channel at edges. Soft, rolled edges add comfort, prevent paper cuts.
- Extra-wide bottom sheet of rugged, water-repellent paper overlaps top sheet to prevent side leakage. Good friction prevents slip.
- Can be autoclaved repeatedly—stays softer and more absorbent than other pads.
- For even greater savings, Ward Pad may be combined with Incontinent Pad for quantity discount.

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WARD PAD

BAUER & BLACK

*Trademark of the I. C. P. Co.

Division of The Kendall Company
309 West Jackson Blvd. Chicago 6, Illinois

save
time
space
breakage
money

with Lederle's new

CENTURY-PAK*

packages

Lederle now makes available in the CENTURY-PAK nine of its products most frequently used by hospitals. Special, sealed polyethylene bags each contain 100 capsules or tablets. CENTURY-PAK shipments come packed in compact fiber drums.

CENTURY-PAK saves time formerly wasted in counting and dispensing from bulk containers.

CENTURY-PAK saves storage space, eliminates bulky bottles.

CENTURY-PAK eliminates loss from breakage of glass containers.

CENTURY-PAK *Lederle* products cost less than in conventional bottles.

The following *Lederle* products are now available in the CENTURY-PAK, on hospital orders for quantities of 5,000 or more:

FOLBESYN† *Vitamins* TABLETS
GEVRAL† *Vitamin-Mineral Supplement* CAPSULES
LEDERPLEX† *Vitamin B Complex* CAPSULES *and* TABLETS
PERIHEMIN† *Iron-B12-C-Folic Acid-Stomach-Liver Fraction —Purified Intrinsic Concentrate* CAPSULES
PERIHEMIN JR. CAPSULES
PRENATAL CAPSULES
VI-ALPHA* *Vitamin A* CAPSULES
VI-MAGNA† *Multivitamins* CAPSULES

Lederle

LEDERLE LABORATORIES DIVISION
AMERICAN Cyanamid COMPANY
PEARL RIVER, NEW YORK

†REG. U.S. PAT. OFF. *TRADE MARK

At the patient's bedside
In staff cafeterias
In the hospitality shop
—the all-around dinnerware is MELMAC®

Melmac dinnerware is so dependably break-resistant—seldom needs replacement

. . . it washes hygienically clean, by hand or by machine

. . . its beautiful colors and lustrous finish make foods look temptingly good

. . . it's so light in weight that nurses, kitchen help—all who handle it appreciate its deceptive lightness

. . . it stacks quietly—a big contribution to the hush-hush atmosphere that helps speed patients' recovery

More and more hospitals are using more and more dinnerware made of Melmac molding material!

Investigate Melmac dinnerware and the significant role it can play in *your* hospital. Ask your supplier for full information and samples—or write us for the illustrated booklet, "Of Melmac Dinnerware."

AMERICAN Cyanamid COMPANY
PLASTICS AND RESINS DIVISION
34F Rockefeller Plaza, New York 20, N. Y.

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PREMIUM SALTINE CRACKERS*

baked by NABISCO

delicious with salads!

ONLY 1⅓¢ PER SERVING

Snowflake Saltine Crackers in the Pacific States

other famous "NABISCO INDIVIDUALS"

FOUNTAIN TREATS

less than 1⅓¢ per serving

served with ice cream

DANDY OYSTER CRACKERS

less than 2¢ per serving

served with chowder

RITZ CRACKERS

only 1¢ per serving

served with juices

®

You'll benefit by 6 big advantages when you serve "NABISCO INDIVIDUALS"

1 Cut handling costs
2 Eliminate breakage
3 Crackers always fresh
4 Low cost per serving
5 Top-quality crackers
6 Close portion control

SEND FOR FREE SAMPLES AND BOOKLET

National Biscuit Co., Dept. 23, 440 W. 14th St., New York 14, N. Y.
Kindly send free samples and new booklet "America's Home Favorites."

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Organization.....

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City..... Zone..... State.....

NABISCO

McKesson Portable
Small-Cylinder
Obstetrical Model 442
(with Aspirator)
Resuscitator

AMA Approved

EFFICIENT CONVENIENCE FOR THAT FIRST BREATH!

Prompt, convenient and effective treatment for the Apneic Baby! That's what McKesson's popular "Table-Top" Resuscitator assures.

McKesson's exclusive unobstructed "Table-Top" provides the ideal place for easy immediate treatment—right over the Resuscitator itself!

Write for full information. A McKesson Resuscitator Brochure will come by return mail.

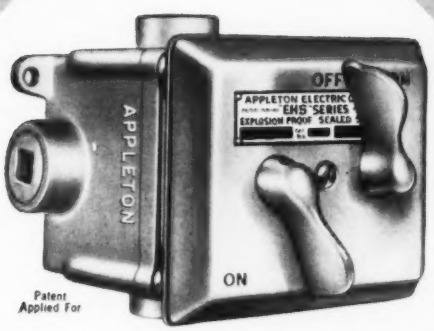
ACCEPTED
COUNCIL ON PHYSICAL MEDICINE AND REHABILITATION
AMERICAN MEDICAL ASSOCIATION

McKesson APPLIANCE COMPANY
TOLEDO 10, OHIO

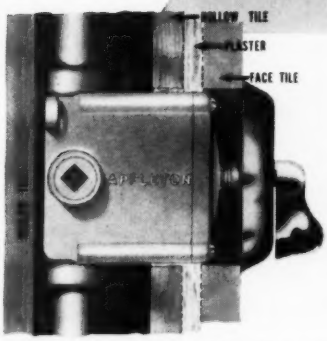
Resuscitators

New, Versatile, Economical

EXPLOSION-PROOF SWITCH by APPLETON



Type "EHS" Two Gang Switch
CLASS 1, Groups C and D



featuring: **An Adjustable Cover offering a range from 9/16" Min. to 1-13/16" Max. to accommodate different wall thicknesses. Also includes a Self-Leveling Adjustment.**

Because of its adjustable cover feature, this "EHS" Series Explosion-Proof Switch is particularly suited to modernization programs. It is quickly and easily installed in walls of different plaster or tile thickness and will compensate for variations up to 5° off level.

"EHS" Series Sealed Switches are typical of *Appleton's* modern design and quality craftsmanship which characterize the entire line of *Appleton* explosion-proof hospital equipment.

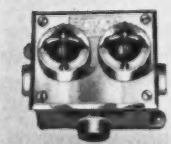
Have you checked the hazardous areas in *your* hospital lately? Why not discuss with your architect or electrical contractor the urgent need for modern explosion-proof protection . . . *Appleton* protection!

X-ray Film Illuminaters for hazardous or non-hazardous locations.

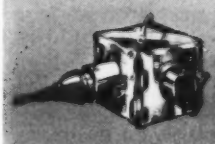
Patent Applied For

Receptacle with Plug.

Patent No. 2273729



Two-gang Pilot Lights. Available in single gang and in combination with switch.



Portable Current Tap with Feed-in Plug.

Sold Through Electrical Wholesalers

APPLETON ELECTRIC COMPANY
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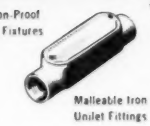
APPLETON ELECTRIC PRODUCTS — REG. U.S. PAT. OFF.

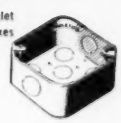
Also Manufacturers of:


Explosion-Proof Lighting Fixtures


Malleable Iron Unilet Fittings


Industrial Lights


Reelites


Outlet Boxes

Anesthetize noise

the fire-safe way . . . with Fiberglas Acoustical Ceilings

Which do you prefer? A quiet, well-run hospital, or a hospital made as safe as possible from the danger of fire?

Fortunately, you don't have to choose between them. You get *both* when you choose Fiberglas* Acoustical Ceilings.

Quiet and Fire-Safety where they count most. Fiberglas Acoustical Ceilings are now in use over the lobbies and corridors, diet kitchens and nurses' stations of America's most modern hospitals.

America's hospitals have helped make Fiberglas Ceilings the largest selling fire-safe ceilings. First, because they absorb up to 75% of all noise, aiding patient recovery and staff efficiency. And look at these other advantages!

Maximum Safety—So fire-safe, they easily satisfy the strictest building codes. Fiberglas Ceilings have the highest ratings for non-combustibility from the U.S. Government and Acoustical Materials Association, and carry the Underwriters' Laboratories label service.

Permanent—Fiberglas Ceilings are beautiful . . . and *stay* beautiful. They can never rot, absorb odors, support termites or fungi. Can never bag or sag, shrink or swell. They're easy to clean, and provide added thermal insulation.

Lowest Cost—Imagine! The *lowest cost* fire-safe ceilings. And they're installed quickly, without major interruption to your normal routine.

We have an informative new booklet that may interest you. It's "The Medicinal Ceiling." Why not write for your free copy now?

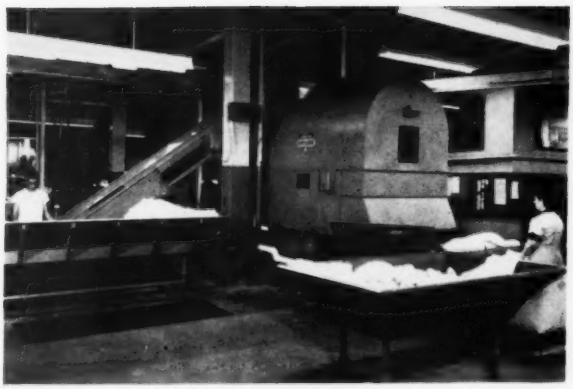
Owens-Corning Fiberglas Corporation, Dept. 141-G, Toledo 1, Ohio

*T.M. Owens-Corning Fiberglas Corporation

OWENS-CORNING FIBERGLAS

SOUND CONTROL PRODUCTS

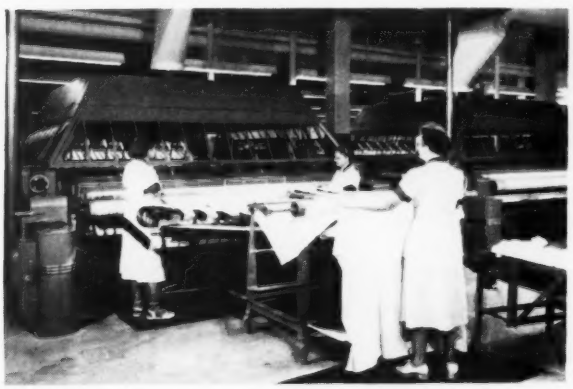
· Textured, Perforated, Sonofaced*, Stria* Acoustical Tile
· Textured, Sonofaced Ceiling Board · Noise-Stop*Baffles.



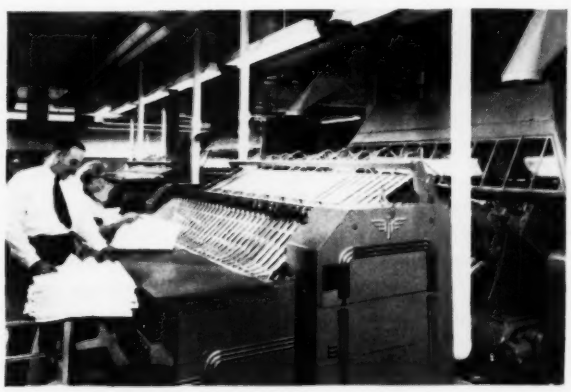
Conveyor-fed 48 x 84" Rotaire Tumbler thoroughly conditions flatwork for fast, smooth ironing—maintains a steady flow of properly prepared pieces to ironers.

Conditioned small pieces hurry by conveyor to feeding operators at Super-Sylon Ironer. Operators feed work directly from conveyor, eliminating manual shakeout.

. . . Faster, Mechanized Workflow All Along The Line



Here, large pieces are *automatically* opened up by mechanical Spreader, for fast, easy feeding to Super-Sylon Ironer. Smooth, mechanized work-flow eliminates manual handling and transporting of work, increases ironer and per-operator production.



Trumatic Folders *automatically* quarterfold large linens coming from Super-Sylon Ironers. Only one receiving operator crossfolds and stacks linens at each ironer. Trumatics are available for folding large linens, or pillow cases, towels, other small flatwork.

. . . Employee Morale Higher, Work Far Less Tiring

SAVES 36,000 Man-Hours Per Year!

In the modernized laundry department of 900-bed Hartford Hospital, Hartford, Conn., smooth balanced work-flow, maximum production and huge labor savings are maintained . . . with American Mechanized Flatwork Ironing!

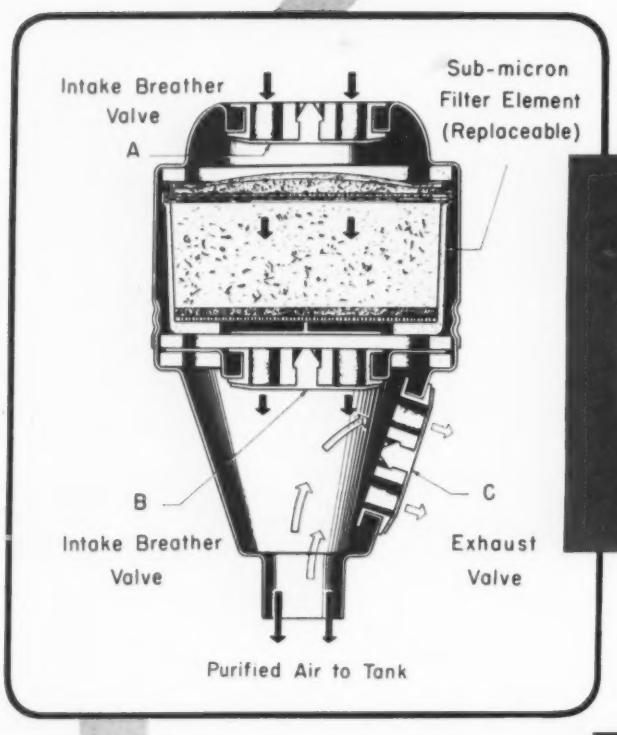
American's Planning and Survey Service can help you slash high labor costs, speed up production—step by step or with a complete installation. Write for Bulletin AD 714-502 on Mechanized Flatwork Ironing!

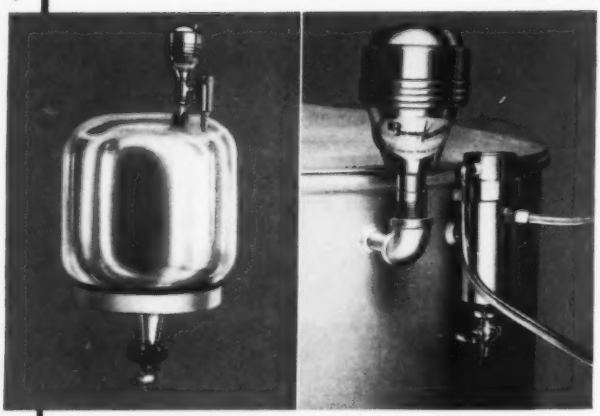
You can depend on your American Laundry Consultant's advice in your selection of equipment from the *complete American Line*. Backed by our 86 years experience in planning and equipping laundries, he can help solve your clean linen problem. Ask for his specialized assistance anytime . . . no obligation.

The AMERICAN LAUNDRY MACHINERY CO.
CINCINNATI 12, OHIO

World's Largest, Most Complete Line of Laundry and Dry Cleaning Equipment.

WHETHER IT'S DISTILLED WATER IN PYREX OR METAL TANK





NEW Barnstead VENTGARD

PROTECTS DISTILLED WATER

from Bacteria, Dust, Mist and Gases

Research scientists and technicians have long been concerned with contamination brought into distilled water storage tanks by air which enters and replaces the distilled water drawn off. As specialists in Distilled Water Equipment for over 75 years, Barnstead now offers the NEW Ventgard.

Employing a replaceable filter element which also contains a special combination of chemicals, the Ventgard is effective in trapping particles, dust, mist, radioactive dust, bacteria etc. Tests show 100% efficiency even with particles as small as 0.2 micron. Bacteria such as tuberculosis, diphtheria, typhoid, tetanus, pneumonia etc., are effectively removed.

In addition, the Ventgard prevents organic vapors, alkali and acid gases from entering the distilled water storage tank. It even removes carbon dioxide, present in concentrations as high as 500 p.p.m. in the average laboratory or hospital room.

A single Ventgard filter element will last 60 days or until 1000 gallons of distilled water have been drawn from tank. The cost of $18. is small indeed, in view of such complete purity protection. Easily installed on your present pyrex or metal storage tanks. ($8. additional for special metal tank fittings.) Filter elements $4. each in cartons of six. When ordering new Barnstead Water Distilling Equipment be sure to specify a Ventgard. Write for Bulletin #131.

AVAILABLE FROM LEADING HOSPITAL AND LABORATORY SUPPLY DEALERS

Barnstead
STILL & STERILIZER CO.
31 Lanesville Terrace, Forest Hills
Boston 31, Mass.

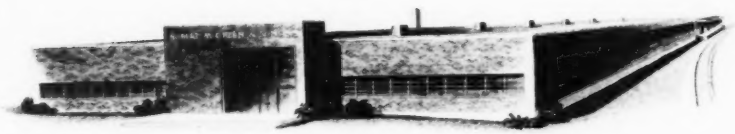
A STILL FOR EVERY HOSPITAL — FOR EVERY HOSPITAL REQUIREMENT

Robert M. Green & Sons, Inc.

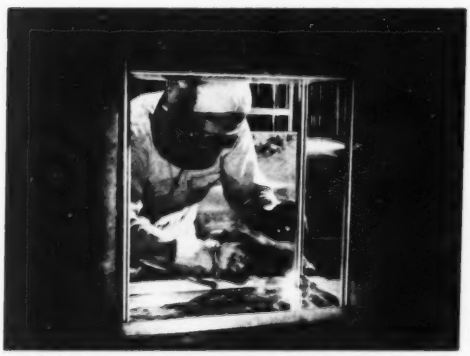
FOUNDED 1874

Introduces a

Complete Line of Hospital Equipment



This new factory of Robert M. Green & Sons, Inc., has just been completed. It is located at Nesquehoning, Pa. There are more than 75,000 square feet of floor area and it is equipped with the most modern high-speed production facilities which make possible a radical cut in delivery time.



Long life and ease of cleaning are built into every piece of Greenline equipment. Rigid, one-piece construction is achieved by using heavy gauge stainless steel with seamless welds that are highly polished. When color is desired, high-grade carbon steel is enameled.

YOU will find many labor-saving features in this new Greenline of hospital equipment. It has been designed with the aid of leading hospital consultants, administrators, physicians and technicians.

This old company has had 78 years of experience in the fabrication of similar equipment. Two years ago it entered the hospital field. Now with a new plant and the latest production facilities, it is ready to provide you with hospital equipment under its trade-marked name—The Greenline.

FINEST QUALITY—LOW PRICE FASTER SERVICE

Each piece in The Greenline is designed to save steps or effort of the user and reduce clean-up time. Long-life is built in by its rugged construction and careful workmanship.

Yet the prices of The Greenline equipment will be no higher than competitive items. And you can obtain delivery in a few weeks instead of waiting several months.

GREENLINE EQUIPMENT AVAILABLE FROM DISTRIBUTORS

Distributors throughout the country are being appointed to handle The Greenline Hospital Equipment. One in your area will serve you as our agent.

Send today for The Greenline catalog. It will give you complete information and specifications for each item in The Greenline.

In the design of special equipment, the engineering staff of Robert M. Green & Sons, Inc., are glad to offer their services. You can be assured by their help of obtaining the finest possible equipment, embodying your ideas and meeting your specific needs and problems.

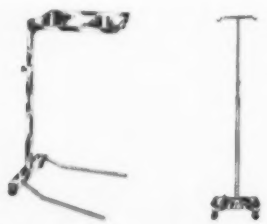
VISIT OUR BOOTH #675 - A H A CONVENTION

SEPTEMBER 13th THRU 16th - CHICAGO, ILL.

THE GREENLINE

EST 1874

REG. TRADE MARK



INS-02 Mayo Instrument Stand, adjustable from 39″ to 60″ by a pressure button. Made of all stainless steel. A popular piece of equipment used in most hospitals.

IRS-01 Irrigator Stand, adjustable from 72″ to 108″. All stainless steel.

UT-02 Utility Table is a popular type, being widely used in many hospitals. Constructed entirely of non-magnetic 18-8 stainless steel. Casters are electrically *conductive*.

KB-01 and SR-01 Kick Bucket and Sponge Receptacle. Both are equipped with non-marking encircling rubber bumpers and electrically *conductive* casters. Made entirely of gleaming stainless steel. Readily cleaned.

This new, electrically heated Food Conveyor incorporates several features that add to convenience in using, increase economy of operation and save time in cleaning. The smooth, one-piece top and wells of stainless steel are welded to eliminate joints and crevices while all corners are rounded.

SEND NOW FOR YOUR CATALOG

There are 230 pages with illustrations and specifications of equipment now in The Greenline. For your convenience the catalog is separated into tabbed sections as follows:

Nurses Station
Hampers, Trucks
Autopsy
Physiotherapy
Wheeled Equipment
Examining
Operating
Casework and Lab.
Nursery
Room Furniture
Food Conveyors
Soda Fountain
Index
Prices

Robert M. Green & Sons, Inc.
Nesquehoning, Pa.

Please see that I receive a copy of your catalog showing the new Greenline Hospital Equipment.

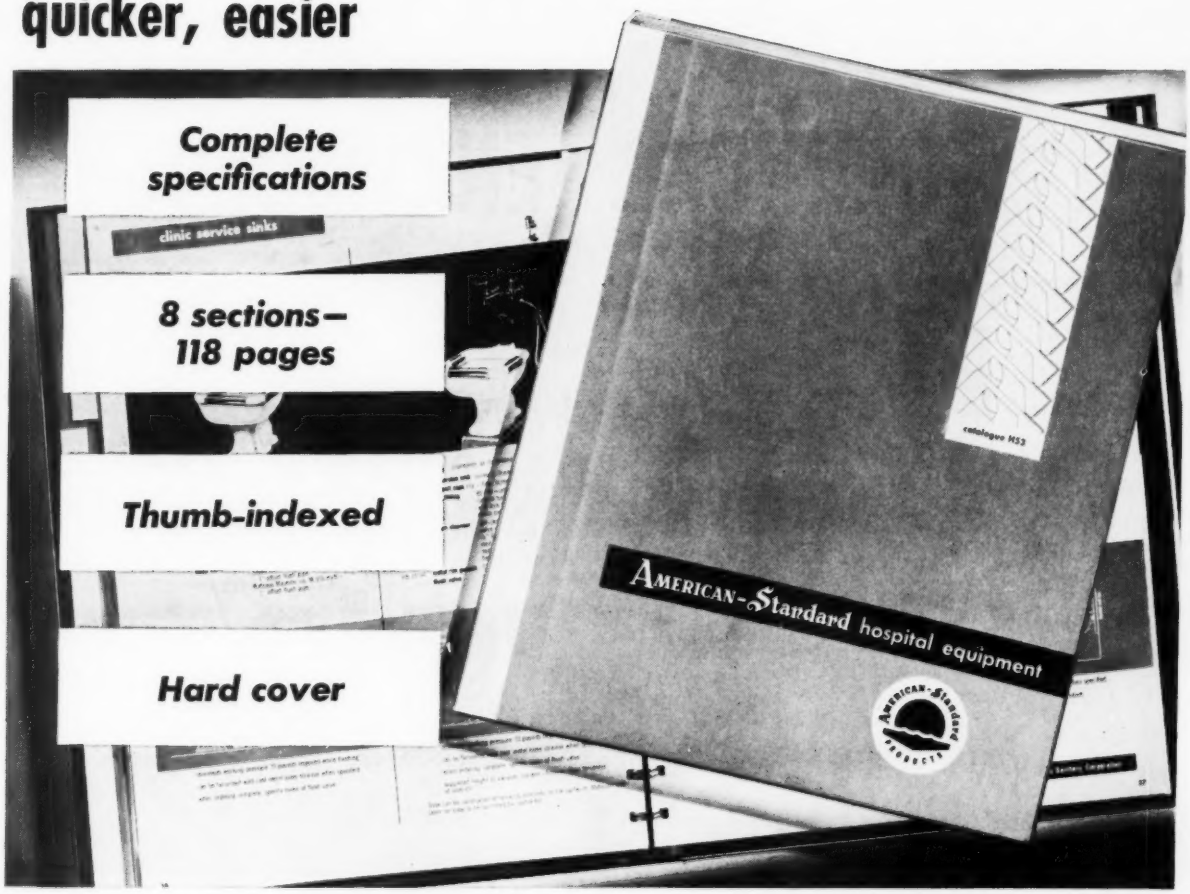
*Name*_____

*Title*_____

*Hospital*_____

*City & State*_____

Now available... to help you select American-Standard hospital equipment— quicker, easier



• Just off the press, the new American-Standard catalogue—H53—contains in one single, compact book complete information on all the American-Standard plumbing fixtures together with a representative selection of heating equipment for hospital use.

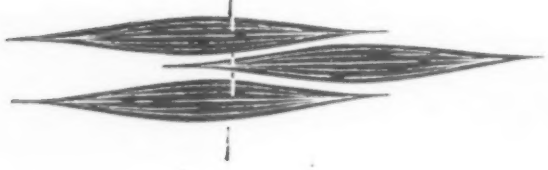
Every possible attempt has been made to save your time. Not only is all the information collected in one volume, but is also systematically arranged and indexed. You can readily turn to the one product section you are interested in and find complete information, drawings and fittings data on every model of this product manufactured by American-Standard. There is no time-wasting hunting for specific products, no necessity for referring from one section to another for further details.

This new hospital catalogue is another step forward by American-Standard in its effort to make sure that complete information, in easy-to-use form, is available on all the famous American-Standard products. For your copy of this new catalogue check with the American-Standard sales office serving you.

AMERICAN-Standard

American Radiator & Standard Sanitary Corporation, P. O. Box 1226, Pittsburgh 30, Pa.

Serving home and industry: AMERICAN-STANDARD • AMERICAN BLOWER • CHURCH SEATS & WALL TILE • DETROIT CONTROLS • KEWANEE BOILERS • ROSS EXCHANGERS • SUNBEAM AIR CONDITIONERS



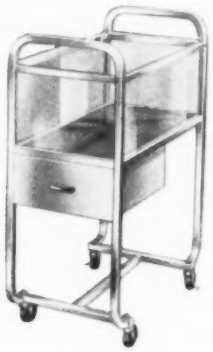
Presented with Pride...

Four Basic Units for Your Modern Nursery

Aloe Alumiline Bassinets with the Steeline Pediatric Table make it easier to realize the ideal concept of the modern nursery: aseptic design, individual care, safe-guards against cross infection, etc. Invite your Aloe representative to show you how to modernize with Aloe units at costs far below that for comparable units.

1. Magee Combination Bassinet and Dressing Stand

Model P9913. Individual care combination unit including bassinet, dressing stand and storage facilities. Transparent sides eliminate need for cubicles. Ideal for "rooming in" care and isolation. Welded square aluminum tubing. Size, over-all: 30 by 28 by 47 inches.



2. Ravenswood Bassinet

Model P9907. Generous space, 16½ by 28⅝ inches, permits complete care of infant inside bassinet. Welded aluminum frame; transparent Lucite sides. Bottom tilts. Size, over-all: 18 by 30 by 38½ inches. With drawer located on side or end, or without drawer.

3. Cabinet Model Ravenswood Bassinet

Model P9904. Complete individual care with adequate storage space for supplies, blankets, etc. Large compartment accessible from either side through sliding transparent Lucite doors. Drawer has ample capacity for bottles, etc. Size, over-all, 18 by 30 by 38½ inches.

4. New Steeline Pediatric Table

Model P8558. Includes built-in tare balance scale, measuring rod, foam rubber cushion and electrical facilities, built-in paper sheeting roll holder; two roomy drawers; large open compartment with shelf. Construction features all-welded steel body.

SINCE 1860

A. S. ALOE COMPANY

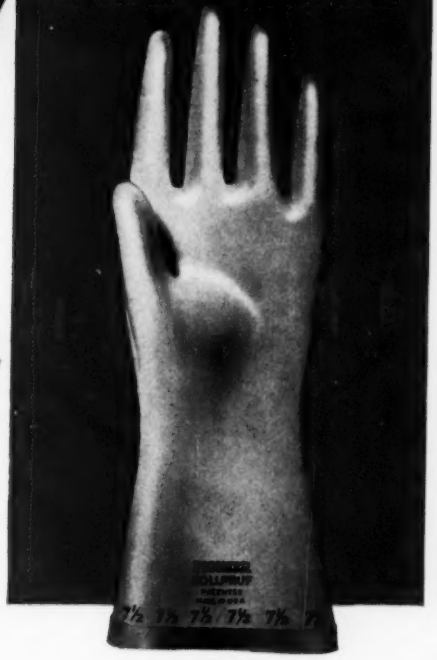
AND SUBSIDIARIES

1831 Olive Street • St. Louis 3, Mo.

LOS ANGELES, SAN FRANCISCO, SEATTLE, MINNEAPOLIS
KANSAS CITY, NEW ORLEANS, ATLANTA, WASHINGTON, D.C.

Tough

...stand many extra sterilizations



PIONEER® ROLLPRUF Surgical Gloves

Rollprufs actually stand extra trips through the autoclave, the result of special processing developed by PIONEER in 35 years of research. Hospital conducted tests show no perceptible loss of strength after ten sterilizations—excellent condition after twenty is common. Rollprufs' flat banded cuffs cling to surgeon's sleeve—no roll down to interrupt surgery. Bands also increase glove life, cut replacement costs by reducing tearing. Tissue-thin sheerness of Rollprufs gives utmost finger-tip sensitivity—allows almost barehanded dexterity.

Multi-size markings are clearly printed across cuffs like this:

$7\frac{1}{2}$ $7\frac{1}{2}$ $7\frac{1}{2}$ $7\frac{1}{2}$ $7\frac{1}{2}$ $7\frac{1}{2}$

Simplify glove sorting—save time and expense. Specify PIONEER Rollpruf Surgical Gloves—finest latex or non-allergic neoprene.

Available from leading Surgical Supply Houses.

Either-hand examination gloves. Short wrists permit quick easy donning for dressings, treatments. One glove (not a pair) fits either hand—no sorting necessary. Latex or non-allergic neoprene.

the PIONEER Rubber Company

350 Tiffin Road • Willard, Ohio

Makers of fine surgical gloves for 35 years

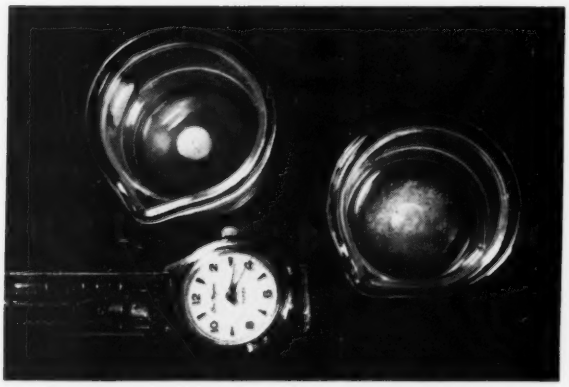
here's why your patient gets

3:15—Disintegration Test begins in actual stomach fluids (pH 2.7). Beaker at left contains ordinary enteric-coated erythromycin. At right is new *FILMTAB*® ERYTHROCIN Stearate (Erythromycin Stearate, Abbott).

Earlier Blood Levels *from*

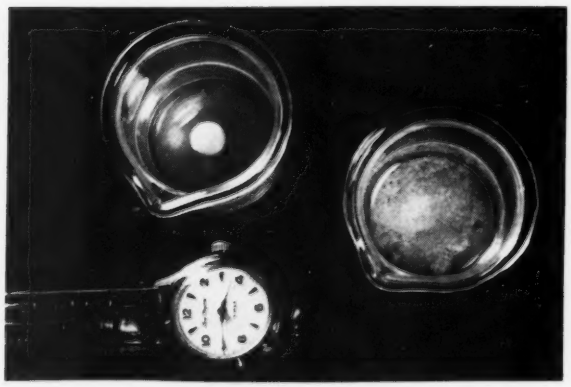
filmtab* ERYTHROCIN®

- DISINTEGRATES FASTER THAN ENTERIC COATING
- HIGH BLOOD CONCENTRATIONS WITHIN 2 HOURS

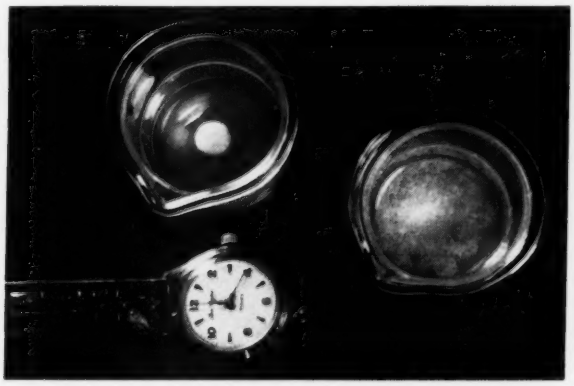


3:20—Five minutes later, *Filmtab** coating has already started to disintegrate. The tissue-thin film actually begins to dissolve within 30 seconds after patient swallows tablet.

3:30—*Filmtab** is now completely dissolved. At this stage, ERYTHROCIN is ready to be absorbed, and ready to destroy sensitive cocci—even those resistant to other antibiotics.



3:45—Now the *Filmtab** tablet mushrooms out with all of the drug available for absorption. Note that enteric-coated tablet is still intact. Tests show that the new Stearate form definitely protects ERYTHROCIN against gastric acids.



4:00—Because of *Filmtab** (marketed only by Abbott) the drug is released faster, absorbed sooner. In the body, effective ERYTHROCIN blood levels now appear *in less than 2 hours* (instead of 4-6 hours as before). Abbott

*TM for Abbott's film sealed tablets, pat. applied for.

407150

MAINTENANCE ECONOMY IS MEASURED BY A PAINT'S WASHABILITY!

NEW Lyt-all FLOWING FLAT is actually SCRUBBABLE!

SO EASY TO APPLY

Rolls or brushes on without pull or drag — levels smoothly without laps, streaks or sags.

NO OBJECTIONABLE ODOR

— either while painting or afterwards. Use a room as soon as the paint dries — a matter of a few hours.

EXCEPTIONAL HIDING

One coat — rolled or brushed on — usually covers previously-painted surfaces.

REQUIRES NO PRIMER

Can be used on any new or previously-painted wall surface without priming.

FOR ANY WALLS

— plaster, wallboard, cement, concrete, cinder blocks, brick and similar surfaces — and on adjacent trim of wood or metal.

Here's a *new* paint — your better Alkyd flat enamel for walls and adjacent trim — with a surface so hard that dirt can't penetrate. It's not only washable over and over again — *it's literally scrubbable!* Even ink, mercurochrome, crayon, lipstick, food stains, shoe polish, iodine and other stubborn substances are easily removed.

Think what that means to your maintenance budget! Those extra washings between repaintings spell welcome economy — real savings. And the first cost of Pratt & Lambert *New* Lyt-all Flowing Flat is reasonable, too.

Administrators who have first critically tried it in a room or two, have quickly standardized on one or more of the 24 Calibrated Colors of *New* Lyt-all Flowing Flat. For saving and durability — for color and eye appeal — they all agree it's the finest wall coating for either new work or maintenance. The next time you paint, try Pratt & Lambert *New* Lyt-all Flowing Flat.

PRATT & LAMBERT - INC.

A Dependable Name in Paint Since 1849

NEW YORK BUFFALO CHICAGO FT. ERIE, ONT.

KAISER FOUNDATION HOSPITAL

Famous Los Angeles "Hospital of the Future", with its many modern patient care and comfort features and self service push button devices, is expected to cut the cost of patient care below that of any standard hospital. Note innovations in maternity room in photo at left.

WOLFF & PHILLIPS, Architects • **THOMAS TAYLOR**, Mechanical Engineer
F. D. REED CO., Plumbing Contractor • **CRANE CO.**, Plbg. Wholesaler

Double Safe Showers Here

Are Controlled by POWERS

Thermostatic WATER MIXERS

Refreshing, relaxing showers without danger of scalding or unexpected shots of hot or cold water are assured by the double safety of Powers Mixers. Because they are *thermostatic* they fully protect bathers from both causes of scalding — **pressure** and **temperature** variations in water supply lines.

Powers mixers are completely automatic, always hold shower temperature where bather wants it. Failure of cold water supply instantly shuts off the shower. Delivery is *thermostatically* limited to 115° F.

Powers Mixers Save Water. No time or water is wasted by bather having to get out from under shower because of fluctuating shower temperature. Water conservation feature alone makes Powers mixers a profitable investment. (b81)

For Utmost Comfort, Safety and Economy Specify and Install Powers Mixers

Established in 1891 • THE POWERS REGULATOR COMPANY • SKOKIE, ILL. • Offices in Over 50 Cities

Take a New Look at Washroom Savings...

NIBROC® TOWELS

dry drier faster!

Any way you look at it, Nibrocs are your best paper towel for *real* washroom economy . . .

Save users' time—faster absorbency speeds up washroom traffic.

Save towels—better wet strength means one towel does the job.

Save on maintenance costs—Nibroc cabinets hold more towels.

Build goodwill—users like their lint-free softness.

Industry uses more Nibrocs than any other paper towel. Why not take a new look at your washroom economy and buy Nibrocs?

NEW SOFWITE AND SOFTAN TOILET TISSUE

Super-Quality Nibroc Tissue is softer because "NIBROCRAFTED."* Costs no more than ordinary tissue. Save by ordering towels and tissue together. See your classified directory for nearest Nibroc dealer. Or write us at Boston—Dept. PN-7—for samples.

*A unique combination of fibres, exclusive with Brown Company, produced after years of research.

BROWN COMPANY, Berlin, New Hampshire
CORPORATION, La Tuque, Quebec

General Sales Offices:
150 Causeway Street, Boston 14, Mass., Dominion Square Building, Montreal, Que.

TWO GREAT NAMES...

HOTEL COMMODORE

42nd STREET AT LEXINGTON AVENUE, NEW YORK 17, N. Y.

Equipped with **GARLAND...**

THE GREATEST NAME IN COMMERCIAL COOKING!

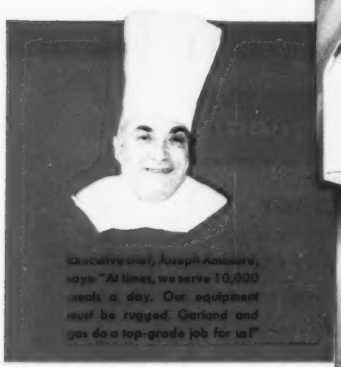
From coast to coast . . . Garland is FIRST CHOICE over all others!

What are the reasons for Garland's clear-cut sales superiority?

Naturally, these reasons vary according to the job!

Short-order cooks like its speedy ways and economy! Popular restaurants like Garland *flexibility-with-quality* performance. Hotels like its rugged durability and efficiency, too!

But whatever the job . . . *Garland does it best!* That's why Garland equipment is used in more leading restaurants, hotels, clubs, schools and institutions than any other make! Get the Garland story from your food service equipment dealer.



Executive chef, Joseph Amoure, says "At times, we serve 10,000 meals a day. Our equipment must be rugged. Garland and gas do a top-grade job for us!"

The battery formation illustrated includes: Spectro-Heat Hot Top; Open Top; Unitherm Fry Top; Deep Fat Fryer; and Side Fired Broiler. Units available in standard black-Japan or Stainless Steel finishes.

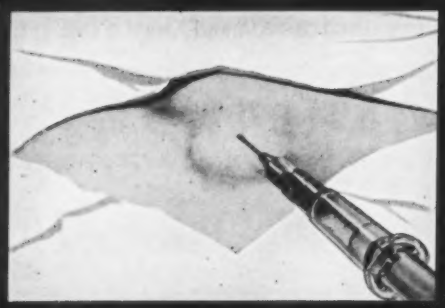
Look for the 45-29 Club pin . . . it's the mark of an expert!

GARLAND

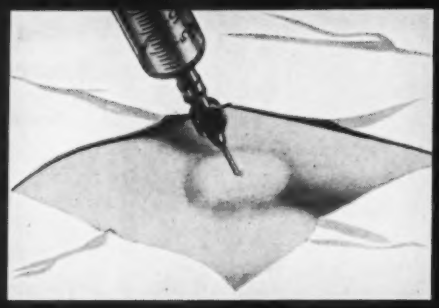
DM PRODUCTS

Heavy Duty Ranges • Restaurant Ranges • Broiler-Roasters • Deep Fat Fryers
Broiler-Griddles • Roasting Ovens • Griddles • Counter Griddles • Dinette Ranges

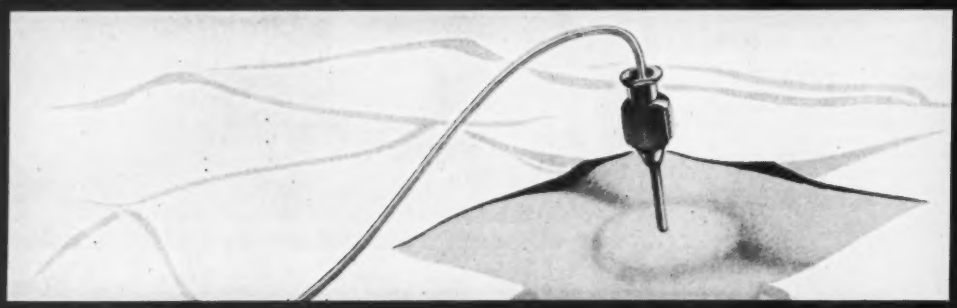
PRODUCTS OF DETROIT-MICHIGAN STOVE CO., DETROIT 31, MICHIGAN
IN CANADA: GARLAND-BLODGETT LTD.—1272 Castlefield Ave., Toronto



A wheal is produced with Novocain



Caudal analgesia is achieved with Pontocaine



Length of sterile plastic tubing is inserted through needle into caudal canal

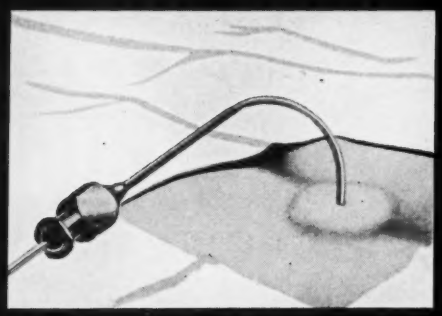
SIMPLE EFFICIENT "WELL TOLERATED" METHOD

OF ABOLISHING PAIN FOLLOWING HEMORRHOIDECTOMY

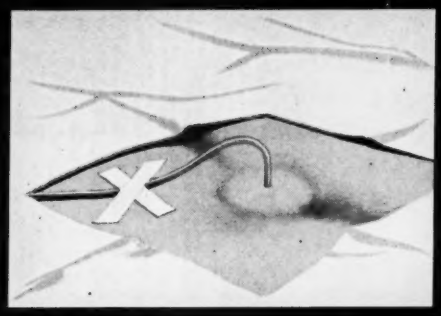
The distressing pain of the first 48 hours following hemorrhoidectomy can be abolished, according to Drs. Gerwig, Alpert, Coakley and Blades, by a new technic described in *Surgery* for November, 1953.

Caudal analgesia with Pontocaine hydrochloride 0.15 per cent solution is used during and following the hemorrhoidectomy. A skin wheal with 1 per cent Novocain solution is made over the sacral hiatus. Through the anesthetized area, a special 18 gage, 2½ inch thin-walled caudal needle is inserted into the caudal canal. Following the initial Pontocaine injection the syringe is disconnected, leaving the needle in place, and a length of sterile plastic tubing is introduced through the needle into the caudal canal. The needle is withdrawn, the tubing taped in place, and a needle and adapter inserted in the free end of the tubing. Pontocaine solution is injected through the tubing at 3 to 7 hour intervals as needed to abolish pain during the next 48 hours.

A special illustrated folder, giving detailed explanation of this new technic, is available on request.



Needle is removed over tubing



Tubing is brought to front and strapped

Pontocaine hydrochloride 0.15 per cent solution is injected through tubing every 3 to 7 hours

THIS NEW POSTHEMORRHOIDECTOMY TECHNIC EMPLOYS:

PONTOCAINE®
hydrochloride

5 Hour Nerve Block

For surgical, diagnostic and therapeutic nerve block, for continuous caudal analgesia and for infiltration — 0.15 per cent solution, vials of 100 cc.; "Niphanoid,"® ampuls of 250 mg.

For 2 to 3 Hour Spinal Analgesia

"Niphanoid" 10 mg., 15 mg. and 20 mg.; 1 per cent solution, ampuls of 2 cc. (20 mg.); 0.2 per cent in dextrose 6 per cent, ampuls of 2 cc. (4 mg.); 0.3 per cent in dextrose 6 per cent, ampuls of 5 cc. (15 mg.). (Supplied in ceramic imprinted ampuls.)

For Topical Application

0.5 and 2 per cent solution; 0.5 per cent eye ointment
0.5 per cent ointment

NOVOCAIN®

Supplied as:

Novocain crystals in ceramic imprinted ampuls, each containing 50 mg., 100 mg., 120 mg., 150 mg., 200 mg., 300 mg., 500 mg. and 1 Gm.

Novocain solution 1 per cent and 2 per cent in ceramic imprinted ampuls and in vials of 30 cc. and 100 cc. Plus other concentrations and forms with and without vasoconstrictors.

Pontocaine (brand of tetracaine) and Novocain (brand of procaine hydrochloride), trademarks reg. U. S. Pat. Off.

WINTHROP

WINTHROP-STEARNS INC.
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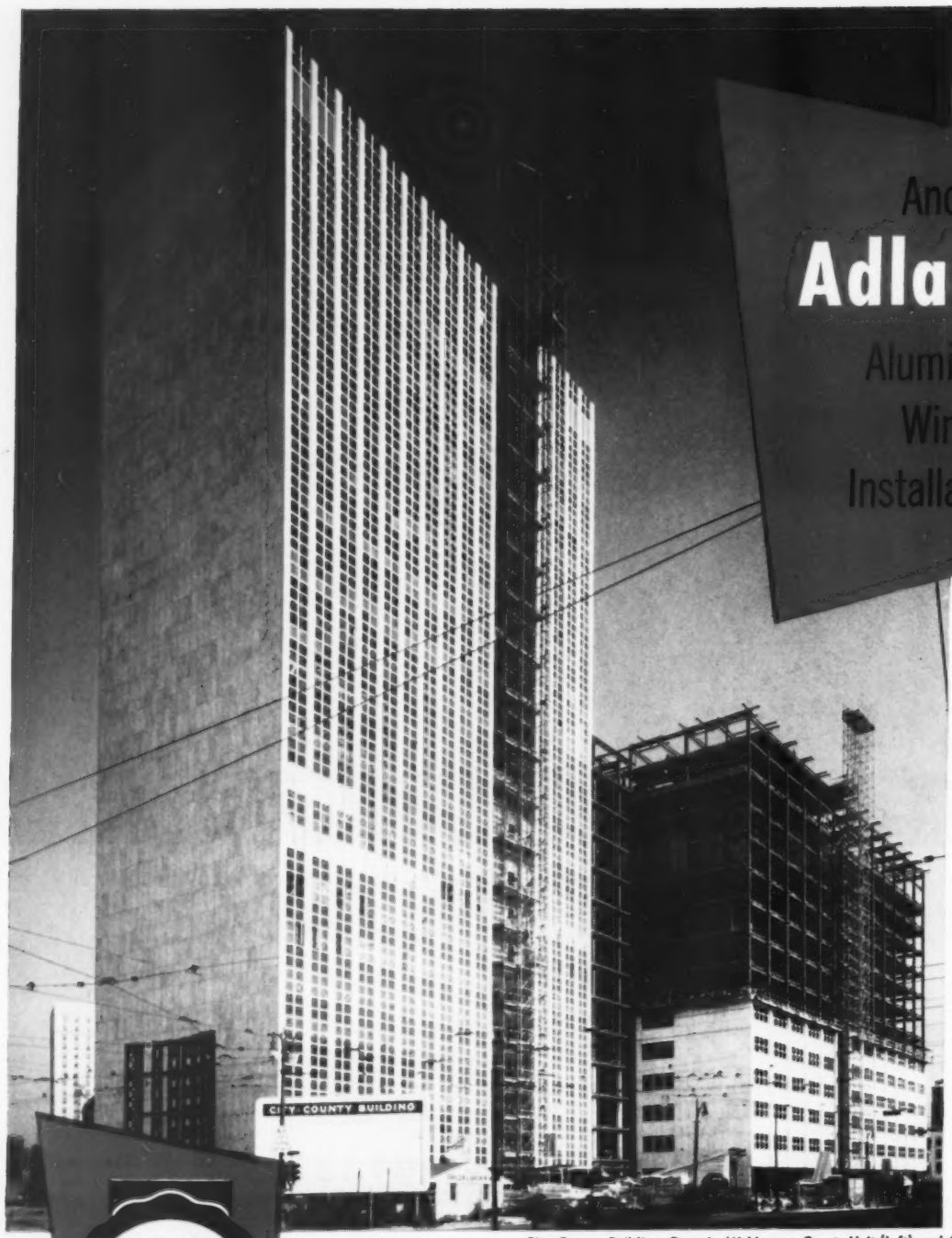

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Small Hospital Questions

Records in Arrears

Question: Our new Hill-Burton hospital has been open less than 18 months, and already we are having "medical record" trouble. The active staff includes about 20 members, but there are probably 60 others from our own and near-by counties who are consultants and courtesy staff members. In a recent analysis of 856 discharges, 549 charts were incomplete!

The records committee of the staff has repeatedly sent notice to the offenders, even going so far as to threaten suspension of hospital privileges. The offending group includes some of our best doctors. Our record librarian is doing the best she can. The trouble seems to be that many of our staff members have not had any hospital responsibilities before. The trustees are interested in good hospital service but have hesitated to put any pressure on the staff. Can you suggest remedial steps?—O.M., Iowa.

ANSWER: It must be understood that, in a new hospital organization like yours, positive action to discipline offenders must be preceded by a long process of education and discussion of hospital problems. We take it that you and your board want to achieve accredited standing for your hospital, but that staff members are not familiar with, or sold on, the desirability of accreditation.

We suggest that, in cooperation with one or more of your staff members who do understand the desirability of achieving accredited status and the necessity of keeping records up to date, you might arrange to have one of the leading staff members from a hospital of unquestioned reputation in a near-by, larger city, or possibly an officer of your state medical society, visit your hospital and address a meeting of the medical staff on the importance of medical records. We suggest, too, that you might solicit a visit by a representative of the Joint Commission on Accreditation of Hospitals, or one of its participating organizations, to discuss these problems with the staff. It should be emphasized, however, that it will take time to persuade a staff that is unaccustomed to these responsibilities. Eventually, of course, it may be necessary to suspend the staff privileges of some few "incorrigibles." For the time being, however, it seems to us that any such drastic action would only cause misunderstanding and resentment, and would not accomplish the desired result of improving record performance.

Cash Discount

Question: Is it in order for the accounting department to take a cash discount on a purchase if the invoice bears the notation that discounts are not granted? If there is no mention on the invoice regarding cash discounts?—E. W., Ohio.

ANSWER: The practice of granting a 2 per cent discount for payment within 10 days is widespread enough in American business to justify deduction of the 2 per cent cash discount from payments on invoices, even when there is no specific mention of the cash discount on the invoice itself. Certainly, however, payment must be made in full if the company then protests it does not allow a cash discount, or if the invoice carries a specific notation that such discounts are not granted.

Salesmen's Calls

Question: How can an administrator who does most of the purchasing in a small hospital arrange her time in order to see salesmen when they call?—J. M., Ind.

ANSWER: Most administrators of small hospitals in rural areas understand that it is unfair and unwise to adopt rigid restrictions for salesmen's visits, such as one day a week, or at certain hours of the day only, as is done in many large metropolitan hospitals. This is unfair to the salesman who may travel a long distance to call on the hospital, and unwise for the administrator who may thus rule out many informative and stimulating visits with salesmen. On the other hand, the small hospital administrator has many duties and cannot afford to be interrupted continually in order to see salesmen. The only sensible procedure would appear to be the development of a preferential system under which the administrator's schedule is so arranged, and salesmen calling on the hospital understand, that there are preferred days, or preferred hours of the day, for salesmen's visits—with the idea that salesmen will attempt as far as possible to observe these preferences.

Conducted by Jewell W. Thrasher, R.N., Frazier-Ellis Hospital, Dothan, Ala., William B. Sweeney, Windham Community Memorial Hospital, Willimantic, Conn.; A. A. Aita, San Antonio Community Hospital, Upland, Calif.; Pearl Fisher, Thayer Hospital, Waterville, Maine, and others.

Staff Assessments

Question: Among the many new small hospitals that have been established since the war, we understand there are a number having financial difficulties, owing largely to low occupancy. Can you tell us if any of these hospitals have adopted the policy of meeting deficits by assessing members of the medical staff for use of the hospital?—R.M., Tenn.

ANSWER: Unquestionably, there have been instances in which hospital boards have called on members of the medical staff to help out in a financial crisis. It is reported from time to time, too, that a few hospitals have established a regular assessment or charge against members of the medical staff. Certainly, however, the practice is not widespread, and it would appear to violate the traditional relationship of the medical staff to the voluntary hospital.

Buying Ahead

Question: For how long in advance should consumable goods be purchased?—D.W., N.J.

ANSWER: At a recent symposium on purchasing for hospitals, an outstanding authority said, "Most people think prices can only go down, so inventories are being reduced generally to a six weeks' basis, except on items which there is some reason to believe may be in short supply." On the other hand, where storage space is not a problem, many hospitals have continued the practice of buying most items, including canned goods, six to 12 months ahead.

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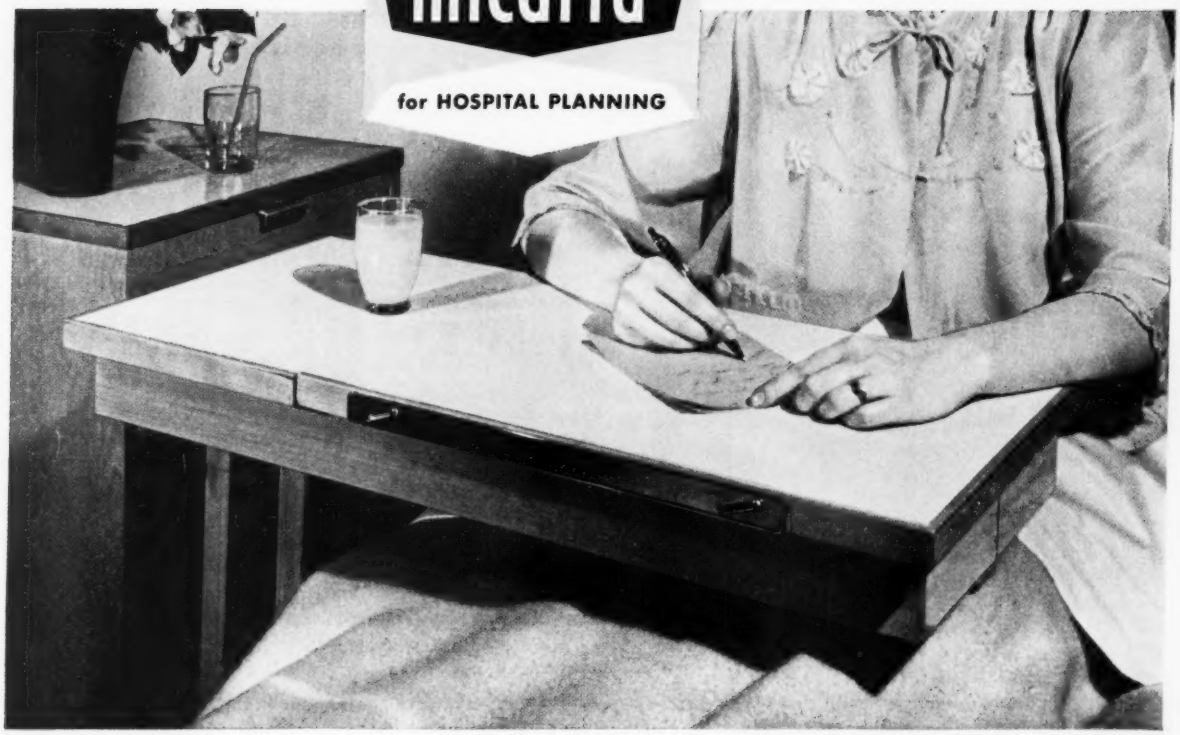

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AUTOMATIC NURSE

Government scientists have developed an electronic instrument automatically to detect and record changes in the physiological condition of a patient while under anesthesia. It measures changes in blood pressure, heart beat, and respiration and presents the data on a panel for interpretation by the surgeon or anesthesiologist. A recording device incorporated in the "physiological monitor" makes a permanent record of the readings.

The device was developed by the National Bureau of Standards under the sponsorship of Veterans Administration.

In announcing the machine, the Bureau of Standards said: "It should prove of great value in the prevention and control of emergencies which may unexpectedly confront the surgeon at the operating table or during certain critical postoperative periods. The instrument is also expected to be a distinct aid in those phases of medical research, such as studies of the effect of drugs on blood pressure, that require a knowledge of the behavior of physiological variables over long periods."

Although the monitor has been tried out successfully in two hospitals, it is not yet on the market.

H-B PROSPECT GOOD

This Congress is smiling nicely (and generously) in the direction of hospitals. By the end of June, the hospital industry could be encouraged by two developments:

1. **The regular Hill-Burton** program for federal grants to build and construct complete hospitals, or facilities attached to complete hospitals, was assured a substantial appropriation.

2. **Legislation** for expanding the Hill-Burton program to take in chronic disease hospitals, nursing homes, vocational rehabilitation centers and health centers was just about assured of passage, and without any really damaging amendments.

The regular Hill-Burton appropriation ran into trouble at only one of the legislative stop-points, the House appropriations committee. There the chairman of the subcommittee responsible for the Hill-Burton fund, Rep. Fred Busbey (R.-Ill.), has a reputation as a bitter critic of Hill-Burton. It was he last year who engineered a report denouncing the program and its administration.

This year the committee, as expected, directed one volley at Hill-Burton, but most of its fire was loosed at Secretary Hobby, whose Department of Health, Education and Welfare supervises the hospital construction activities. The committee report noted at least a dozen places where the Secretary hadn't asked enough money—or had asked too much. The committee was particularly incensed because Mrs. Hobby, after being refused greater discretion in shifting funds last year, still was able to scrape up $100,000 in various ways to build herself a special "chart room" adjoining her office.

On Hill-Burton the report accused "those at the head of the department" of deceptive testimony to justify a $75 million appropriation. Originally, the Budget Bureau had authorized a $50 million request. Later, the Administration reversed the Bureau and sent word to Capitol Hill that $75 million was justified.

Spokesmen for Mrs. Hobby's department told the subcommittee that the additional $25 million was requested because Congress might not get around to expanding the program, and that the extra money would then be needed to finance health centers. The committee decided that "this sounded more like an excuse than a reason." But the committee must have been about 60 per cent convinced; it recommended a $65 million appropriation.

The $65 million figure ($10 million less than the Administration requested) didn't stand up for long. In House debate on the appropriation bill a few days later, the $65 million was raised to $75 million, to the accompaniment of words of high praise for the way the program has been conducted.

In the House, Rep. Edgar A. Jonas (R.-Ill.) led the fight to restore the $10 million. He declared:

"In recent years hospital construction under the hospital survey and construction program has amounted nationwide to about one-third of our total hospital construction, exclusive of purely federal construction. Total civilian hospital construction has been at a level which has barely kept up with the increase in population. If the hospital survey and construction program is to be only $65 million next year, no inroad can be made into the accumulated bed deficiency. . . ."

Rep. Percy Priest (D.-Tenn.), a strong supporter of hospital and medical legislation, declared:

"This Hospital Survey and Construction Act in its administration has, in my opinion . . . been one of the most successful of all our federal-state cooperative programs over the years.

"The state authorities have in most instances exercised great wisdom in the development of their state plans. There has been the very closest cooperation among those state authorities . . . and all of the program has gone forward.

"There has been a smoothly operating, cooperative program between the states and the federal government, and this $10 million is needed."

Rep. Charles Wolverton (R.-N.J.), the highly respected chairman of the interstate and foreign commerce committee, which handles most health matters but not money bills, also joined in to support the larger fund, declaring:

"There is not a single state or territory which has not derived great benefit from the program. . . . I should like to remind the members of the great good that has in the past and will in the future accrue from a program such as this which provides hospital services to great segments of our

population that heretofore were deprived of adequate hospital service. . . . Can we overlook the significant fact that these hospitals afford an appropriate place for the physician and other health workers to practice their arts and skills in helping humanity?"

Mr. Busbey, of course, led the opposition. He told of a survey he made in "many states." "First of all," he said, "I came to the conclusion that we are building hospital beds faster than we are taking care of staffing them with nurses and doctors. I think this particular division of the Department of Health, Education and Welfare could very well emphasize and pay more attention to the shortages of nurses that exist in almost every hospital in the United States. I wish I had an hour to talk about that particular factor alone. If we had the nurses and the doctors to staff these hospitals, I would be one who would want to expand this program and even to appropriate more than $75 million, if the need existed."

Meanwhile, the bill was having no trouble in the Senate. At this writing a report has not come out of the committee, but in view of the fact that the Senate committee invariably is more generous than the House committee or the House, it is a safe assumption that the total appropriated will be close to $75 million.

NEW TYPE OF FACILITIES

The other Hill-Burton bill, after clearing the House early in the session, made its way through the Senate health and welfare committee with only minor changes. The probability was that it would be the first part of the Eisenhower health program to become law. Under the bill, to be handled by the regular Hill-Burton administrative machinery, an additional $60 million would be appropriated each year for four types of facilities that do not now qualify for H-B grants. They are hospitals for the chronically ill, nursing homes, rehabilitation facilities, and diagnostic and treatment centers.

The Senate committee eased requirements so as to give state health authorities more control over money. It recommended that funds for three of the types of facilities be interchangeable—nursing homes, chronic disease hospitals, and diagnostic and treatment centers. However, it retained the requirement that money voted for rehabilitation centers would have to be used for that purpose.

To reassure the medical profession, the Senate committee also changed the wording to forbid the granting of federal funds to a clinic or health center devoted solely to treatment. It could be used for diagnosis, or diagnosis and treatment, but not treatment alone.

REINSURANCE

Although time is short, the Administration continues to press for action on its reinsurance legislation, which lay undisturbed in the House interstate and foreign commerce committee for two months after completion of hearings. Members of this committee are known to have little interest in bringing out the measure, despite prodding from the White House. In the Senate, the more liberal labor and welfare committee expects to recommend some sort of bill for reinsurance, but the details have not been decided upon.

Mrs. Hobby served notice that there was still life in the bill when she addressed the National Association of State Insurance Commissioners. In testimony before Congressional committees this group denounced the reinsurance idea as impractical and an extension of federal influence in a field where it wasn't needed. Despite this, Mrs. Hobby pleaded with the association to reverse its stand on reinsurance. She said that it was not a subsidy and that in no way would it result in the federal government's interfering with state control of insurance.

The secretary made some progress, but probably not as much as she had hoped for. The resolution finally adopted by the association in executive session was described by some of those present as a polite pledge of cooperation, and nothing more. However, some of Mrs. Hobby's aides regarded it as a withdrawal of opposition.

The evening of the same day Mrs. Hobby addressed the commissioners, President Eisenhower made a national address outlining his legislative program. He listed reinsurance as one of the bills he wanted passed, but it was given no special priority.

Support of the insurance commissioners is considered vital, because they would play a prominent rôle in administering the reinsurance program. Congress would not be expected to enact the bill as long as this group, representative of all state governments, refuses to give the bill approval.

NOTES:

The House was also generous to the National Institutes of Health, boosting their appropriations totals well over recommendations of the committee and in some cases higher than the Administration's requests.

In vetoing a bill to give medical care and hospitalization to a small group of government workers, President Eisenhower used the opportunity to plug for a system of contributory health insurance for all U.S. civil service people. Legislation for this program has not yet been introduced, so there is no chance of its enactment this session.

Fast action by Blue Cross corrected a bad situation in the tax revision bill. As written, health plans would have to "qualify" with Internal Revenue Bureau for tax exemption by establishing certain facts about their operations. Blue Cross pointed out to the Senate committee that, while this would be no problem for the larger plans which have legal and administrative staffs, it might well interfere with operations of the smaller plans. The Senate committee dropped the requirement before reporting out the tax bill.

Henry Kaiser has launched an all-out campaign to arouse public interest and Congressional support for a mortgage guarantee bill that would help clinics such as his to get started. He may win over the public, but he is not likely to make much impression on Congress this session, at least not as long as the Administration continues to oppose his idea.

MORE V.A. PATIENTS

Veterans Administrator Harvey Higley says his agency is planning on a daily patient load of 110,000 in V.A. hospitals during fiscal 1956 (starting July 1, 1955) as against an average this year of 103,000 patients. Commented Mr. Higley to the House veterans affairs committee: "I believe this isn't far off in the Bureau of the Budget's thinking, too." Assuming the same occupancy rate (88 to 90 per cent) would be maintained in fiscal 1956, V.A.'s new goal would mean activation of about 8000 more beds than now staffed (114,315). For fiscal 1955, Senate and House conferees this week agreed on a V.A. budget sufficient to maintain a 105,000 daily load.

The Modern Hospital
JULY 1954

How they put the heat on

DOCTOR MOUSEL'S SALARY

ROBERT M. CUNNINGHAM Jr.

WHEN Dr. Lloyd H. Mousel, director of anesthesia and oxygen therapy at Swedish Hospital, Seattle, filed a complaint in superior court there last month charging the Washington State Society of Anesthesiologists and the King County Medical Society, among others, with conspiring against him to further their own economic interests, he was taking the final, inevitable step in a controversy that has marched relentlessly from climax to climax since Dr. Mousel first visited Seattle, late in 1949, to look into the appointment at Swedish Hospital.

Initially, the issue was whether or not a specialist could practice medicine on a salary and percentage arrangement, with the hospital collecting fees for his services. Anesthesiologists in Seattle, supported by radiologists, pathologists and a substantial number of physicians in private practice there, charged that Dr. Mousel (pronounced mo'-zl) was being "exploited" by the hospital and was thus "unethical" and lending himself to the "corporate practice of medicine" by the hospital.

Whatever the validity of these charges may have been at the time, they appear to have had little foundation in fact since 1951, when Dr. Mousel changed his arrangement with the hospital. Since then, he has insisted that his salary is perfectly ethical, since the payments are made in consideration of his administrative, teaching and supervisory duties, and he bills patients directly on a fee-for-service basis for all anesthesia administered personally by him.

In his complaint, Dr. Mousel alleged that the defendant societies and individuals have conspired continuously to prevent him and other specialists from rendering services of any type on salary in any hospital, and "to damage or ruin the professional reputation of any specialist who accepted such salaried employment, through the practice of social and professional ostracism and other means." The conspiracy was formed, according to the complaint, "to further the economic interests of the practitioners in the respective specialty and to exploit their patients, by requiring from the latter a larger amount of money in the form of fees for services than would be paid by them if members of the specialty performed certain services on a salary."

SYMBOL OF TENSION

Specifically, Dr. Mousel has asked the court to enjoin the defendants from continuing their conspiracy and from refusing to admit him to membership in the State Society of Anesthesiologists and the King County Medical Society, from which he has been successfully excluded thus far.

Actually, much more is at stake than Dr. Mousel's society memberships or his relationship with the hospital. In a way, Dr. Mousel has become a symbol of the mounting tension between doctors and hospitals, in Seattle and elsewhere. Throughout the country, anesthesiologists and other specialists are following the Mousel case with interest and apprehension, aware that the whole structure of their argument against salaried practice may stand or fall as this question is resolved in court. In Seattle, an observer is impressed by the fact that some of the feeling against Dr. Mousel, at least, reflects antagonism toward hospitals on the part of doctors, and especially general practitioners, who are apprehensive about domination or control of medical practice by the hospital.

RELUCTANT MARTYR

Dr. Mousel himself is a reluctant martyr who doesn't look or act the part especially. Graying today at 51, and of medium height and build, he is mild mannered and quiet spoken, though positive and assured of being in the right. He does, however, have some misgivings. "I know what has happened to doctors who bring lawsuits against other doctors," he said soberly not long ago, "and I have a family to support." Nevertheless, Dr. Mousel felt he had no choice but to take this final step. On three separate occasions, his application for membership in the King County Medical Society had been rejected by vote of the members; exclusion from the State Society of Anesthesiologists had cost him his membership in the American Society of Anesthesiologists, and he was threatened with loss of certifica-

tion by the American Board of Anesthesiology. His plans to develop a residency program in anesthesiology at Swedish Hospital had been thwarted, and an appeal to the Judicial Council of the American Medical Association resulted, finally, in the decision that "no further action can properly be taken to implement your admittance to the King County Medical Society."

BIGGER THAN ANESTHETISTS

Informed that Dr. Mousel was about to file his complaint last month, a friend who is chief of anesthesiology at an eastern medical school wrote him as follows: "It is obvious that you have no other course now but the one you are taking. It has appeared to us that the problem has become bigger than just anesthetists, that it now threatens all full-time medicine, that it is a matter which has to be fought out in the A.M.A., that the universities as a group must interest themselves in the problem. Good luck."

No question has ever been raised about Dr. Mousel's professional competence. A graduate of the University of Nebraska Medical School, he was in general practice for several years before he became convinced of the need for better anesthesia practice and went to the Mayo Clinic for residency training with Dr. John Lundy. He remained there as a consultant and instructor in anesthesiology until he entered the army medical corps in July 1942. During the war, he was chief consultant in anesthesiology to the surgeon-general, consultant on the staff of Walter Reed General Hospital, and director of the school of anesthesiology at the Army Medical Center there.

Following his discharge with the rank of lieutenant colonel, Dr. Mousel accepted an appointment as head of the department of anesthesiology at George Washington University Medical School in Washington, D.C. At the time he was offered the appointment in Seattle, he had resigned his hospital position but was professor of anesthesiology at George Washington University Medical School and had a lively practice with private patients.

On an exploratory trip to Seattle in November 1949, Dr. Mousel ran head-on into Associated Anesthesiologists, an unincorporated group of private practitioners having a virtual monopoly on medical anesthesiology in Seattle hospitals. Now named as defendants in the superior court complaint, Associated Anesthesiologists made it explicitly clear to Dr. Mousel on that occasion that he would find the storm flags flying if he came to Swedish Hospital on a salary.

"During the time I visited Swedish Hospital last November, I had the opportunity of meeting with several of this group for the purpose of discussing the practice of anesthesiology in Seattle," Dr. Mousel said in a letter written the following February, shortly before he moved to Seattle. "These men intimated that they are opposed to having Swedish hire a full-time director, hoping of course eventually to eliminate all nurses from the scene and make Swedish an open staff hospital. Thus all anesthesia in Seattle would be done on a private practice basis. It is my personal opinion that Associated Anesthesiologists are much more interested in gaining monopoly in the practice of this specialty in Seattle than they are in actual professional and scientific advancement."

WARNED OF OPPOSITION

During the weeks immediately preceding his move to Seattle on April 1, 1950, Dr. Mousel had letters and telephone calls from a number of his professional friends. "I heard somewhere there was a possibility that you were entering the practice of anesthesiology in Seattle," said a brief note from Dr. Henry S. Ruth of Haverford, Pa., a prominent anesthesiologist and past president of the American Society of Anesthesiologists. "I am wondering if this is true. If you are considering it and have not definitely made up your mind concerning it and would care to tell me, I believe I might have some information which you might or might not care to hear."

By that time, Dr. Mousel had heard it all before, and so had practically everybody else in the specialty, which was buzzing like a high school sorority with reports of Dr. Mousel's appointment.

"Unconfirmed reports in Seattle have it that Dr. Mousel has accepted a position at the Swedish Hospital," Dr. C. B. Wangeman, a member of Associated Anesthesiologists, said at the time in a letter to Dr. Roland Whitacre of Cleveland, a militant anesthesiologist of the private practice persuasion. "According to these reports, Dr. Mousel is coming as a hospital employe with a stated salary plus percentage and will supervise the nurses department of anesthesia, the financial benefits from which go to the hospital. If these reports be true, it would appear that there would be the reestablishment of the practice of medicine by a hospital, where other good anesthesiologists have worked hard to establish and maintain the practice of anesthesiology in accordance with the policies approved in the Hess Report. . . . Feeling is high in Seattle among the anesthesiologists that the principles of the Hess Report should be upheld at any cost, and the local society is unalterably opposed to any practice at variance with the principles established in the Hess Report, which departures in their view would necessarily sell the specialty in this area down the river."

Even then, the possibility of eventual legal action was contemplated.

"I must disabuse you of the idea that we are involved in legal action with Dr. Mousel or the Swedish Hospital," another member of Associated Anesthesiologists said in a letter to a friend in November 1950, when Dr. Mousel had been established at Swedish Hospital for several months. "The Washington State Society of Anesthesiologists has considered this inadvisable except as a last resort. We do have a fund of several thousand dollars raised by assessing each member $150, which could conceivably be put to such use.

"When Dr. Mousel first considered the situation our objections were made clear. However, he disregarded our advice to accept only what we consider an ethical setup and to avoid any type of agreement sanctioning the corporate practice of medicine. He was notified by anesthesiologists both here and elsewhere that he could expect active opposition."

ALLIES CALLED ON

Seeking moral and financial support, the anesthesiologists had turned to their natural allies. "The matter was discussed by joint meetings of the anesthesiological, radiological and pathological societies here," the anesthesiologist's letter went on. "It was decided that all should contribute to the fund to maintain our stand and to resort to litigation as a last resort. . . . There has been for several years a joint committee here from the three specialties for the study of such problems of economics and ethics."

The precise nature of the economic and ethical studies pursued by these

specialty societies in their joint meetings is then set forth in several illuminating paragraphs of this anesthesiologist's letter to his colleague:

"To date the following more or less concrete measures have been taken by the state society:

"1. Opposed Dr. Mousel becoming a member of the county medical society.

"2. We have not invited Dr. Mousel to join the Washington State Society of Anesthesiologists.

"3. To the best of my knowledge he has not been entertained in the home of any of the local anesthesiologists.

"4. We sponsored, at least in part, the recently accepted amendment to the A.S.A. constitution requiring membership in the component society.

"5. We are slowly educating the other specialties, especially the surgeons here, as to our problems. By taking a firm stand without resorting to legal means, we feel that we have so far been winning the fight without losing the respect and confidence of our colleagues."

The nature of the "firm stand" was described, briefly but graphically, at a meeting of anesthesiologists in Philadelphia. "An anesthetist came to Seattle and took a salaried position against the wishes and advice of all the anesthetists in the community," a speaker at this meeting reportedly said. "He was warned not to take the job, but he took it nevertheless. So the anesthetists boycotted him and would have nothing to do with him, socially or professionally. Furthermore, they enlisted the aid of their wives to do the same to his wife."

The alleged sins for which Dr. Mousel and his family are thus being punished have been summarized as follows by a member of Associated Anesthesiologists:

"Our argument against the system set up by Dr. Mousel at the Swedish Hospital may be summarized as follows:

"1. It is contrary to the principles of medical ethics and contrary to the general welfare of the patient.

"2. It is contrary to the medical practice acts of the state of Washington for a corporation to derive profit from the services of a physician.

"3. It is detrimental to the development of anesthesiology in this area and elsewhere and deters the influx of well trained anesthesiologists into this area.

"4. It promotes the practice of medicine by hospitals and will encourage other hospitals in this area to change their systems to one which is more remunerative to them."

"CONFORMED TO A.M.A. POLICIES"

These charges are categorically denied by Dr. Mousel and his supporters, a group which includes a substantial number, at least, of the doctors on the staff of Swedish Hospital, and the hospital's influential board of trustees. Acknowledging that the arrangement under which he came to the hospital early in 1950 might have become unethical, retroactively, in June of that year, when the House of Delegates of the A.M.A. approved the most militant version of the Hess Report, Dr. Mousel and his followers point out that his agreement with the hospital was thereafter changed to conform with A.M.A. policies.

"In March of 1951 I entered the private practice of anesthesia," Dr. Mousel said, "billing my own private patients directly and retaining an income from the hospital paid for the purpose of administering the departments of anesthesia and oxygen therapy, and for teaching and supervision."

While this arrangement would appear to avoid any ethical violation, or any involvement in the corporate practice of medicine, it has failed to satisfy members of Associated Anesthesiologists and others opposing Dr. Mousel —because, apparently, they simply don't believe him. For one thing, Dr. Mousel has steadfastly refused to divulge the amount of his salary and

Timetable of the Mousel Case

NOVEMBER 1949 — Dr. Mousel visits Seattle to discuss appointment with officials of Swedish Hospital and to look into practice of anesthesiology.

APRIL 1, 1950—Dr. Mousel takes up duties as director of anesthesia and oxygen therapy at Swedish Hospital on salary and percentage arrangement.

JUNE 1950—Hess Report approved by A.M.A., raising ethical question about financial arrangement between Dr. Mousel and Swedish Hospital.

FEB. 1, 1951—Dr. Mousel licensed to practice in state of Washington.

MARCH 1951—Dr. Mousel enters new arrangement with hospital, providing for billing of his own patients, retaining salary only for administrative, teaching and supervisory duties.

APRIL 25, 1951—Dr. Mousel advised by American Society of Anesthesiologists that he is to be automatically dropped from membership "unless you present evidence on or before the second day of July 1951 that you have become a member of the Washington State Society of Anesthesiologists."

MAY 12, 1951—On appeal from Dr. Mousel pointing out that his membership in Washington State Society of Anesthesiologists depended on membership in King County Medical Society, then pending, action against him by American Society of Anesthesiologists is postponed.

SEPT. 19, 1951—Having been notified that he could not join King County Medical Society by transfer from District of Columbia society under latter's rules, Dr. Mousel applies for membership in King County Society. Application is assigned to membership committee for investigation and report.

JUNE 2, 1952—Preliminary investigations and notifications having been completed, Dr. Mousel's membership application is voted on for first time by King County Medical Society. Score: 78 for, 117 against application.

NOV. 25, 1952—Dr. Mousel notified he has been dropped from membership in American Society of Anesthesiologists.

NOV. 28, 1952—After six months' delay required in by-laws, Dr. Mousel submits second application for membership in King County Medical Society.

FEB. 12, 1953—Dr. Mousel notified by American Board of Anesthesiology, Inc., that it has commenced proceeding for revocation of his certificate because he is not a member of his county medical society or American Society of Anesthesiologists.

MAY 25, 1953 — Letter from Swedish Hospital board to King County Medical Society states that all anesthesias administered personally by Dr. Mousel are billed directly by him to patient.

OCT. 2, 1953—After necessary preliminaries, second membership application is voted on. Score: for Mousel 102 votes, against 108.

DEC. 3, 1953—Following hearing, Judicial Council of A.M.A. requests society to hold third election.

FEB. 1, 1954—Third vote on membership. Score: 196 for, 162 against.

MARCH 17, 1954—A.M.A. Judicial Council writes Dr. Mousel that "no further action can properly be taken by it to implement your admittance to King County Medical Society."

JUNE 9, 1954—Dr. Mousel files complaint in superior court against Associated Anesthesiologists, Washington State Society of Anesthesiologists, King County Medical Society, etc.

other compensation paid by the hospital. "Either I am wrong in carrying out this type of practice, or I am right in carrying out this type of practice," Dr. Mousel told a visitor recently, in reply to a question about his income. "According to the ethical policy of the A.M.A., I firmly believe I am right. In order to avoid further issue my attorney thinks it is better not to reveal income, but to settle this on the basis of whether or not it is correct. I don't believe my income is relevant to the case. Less than 50 per cent of my income is salary."

NEW AGREEMENT DRAWN UP

Some time after Dr. Mousel had switched to a private fee basis of billing for anesthesia rendered by himself, retaining his salary only for administrative and teaching duties and supervision of nurse anesthetists, members of the King County Medical Society complained that he was still performing some procedures, such as spinal anesthesia, intratracheal anesthesia, and sympathetic blocks, for which patients were not being charged separately.

"The society requested directors of the Swedish Hospital to change that portion of my contract so that I would be charging for everything," Dr. Mousel related not long ago. "The hospital agreed, and in May 1953 I signed an agreement whereby from that date on I would charge private fees for everything that I did. Since that time I have made a personal charge for every spinal anesthetic that I have given. I have always charged for my intratracheals and sympathetic blocks on a private fee basis since I went on that basis in March of 1951. Fees have been small, to be sure, because my total time on most of these patients is short."

By the time this agreement was reached, however, it is doubtful that the opposition to Dr. Mousel could have been subdued by any arrangement short of assassination. The idea that the hospital was making a profit on Dr. Mousel's services had become fixed in the minds of his opponents and could not be dislodged. Moreover, Dr. Mousel himself had become a symbol. A vote against him was a vote against "hospital domination" and "corporate practice" and all the other stereotyped threats to medical independence. In Seattle medical circles, it was widely rumored that members of the Swedish Hospital board were bringing pressure to bear on medical staff members to take a favorable position on Dr. Mousel's case or risk loss of their staff appointments. Bitterness was apparent on both sides.

JUDICIAL COUNCIL'S HEARING

This was the state of affairs when Dr. Mousel's case came up for a hearing in front of the A.M.A. Judicial Council at St. Louis in December 1953. His application for membership in the King County Medical Society had just been rejected, for the second time, by a vote of 102 for and 108 against his application—a resounding defeat, inasmuch as a four-fifths majority in favor of the applicant is required for admission to the society.

Appearing together at the Judicial Council hearing were Dr. Mousel, Dr. J. Finley Ramsay, then president-elect of the King County Medical Society, and Dr. Daniel Moore, a local anesthesiologist. A Seattle surgeon who operates occasionally at Swedish Hospital and has sometimes used Dr. Mousel as his anesthetist, Dr. Ramsay told a reporter later that the hearing was conducted in an open, aboveboard fashion. Earlier, the society had presented a brief reviewing the dates and circumstances under which Dr. Mousel's two applications for membership had been submitted, processed and voted down. Because these votes had been conducted in an orderly, constitutional fashion, the society contended, there was no dispute within the jurisdiction of the Judicial Council of the A.M.A.

"It is Dr. Mousel's contention," the brief then continued, "that a group of anesthesiologists may have misinterpreted the Hess Report and may have been instrumental in his not receiving the requisite number of votes for election to membership in the society. Misinterpretation of facts, it is true, is a hazard that any candidate for office or for membership in a society undertakes when he applies for membership. The important thing is to see that he has a fair chance to be voted on. His supporters had every opportunity to appear at each election and advocate his candidacy and, to use the parlance of the street, 'get the vote out.'

"Dr. Mousel's difficulties seem to stem from his contractual relationship with Swedish Hospital in Seattle and the controversy between him and his fellow anesthesiologists. . . . Under his present contractual relationship, Dr. Mousel reports that he now bills direct for his own private patients and receives a salary income from Swedish Hospital paid for the purpose of administering the department of anesthesiology and oxygen therapy, for teaching and supervision. On its face this would seem to be a correct arrangement, except that the Hess Report does not seemingly authorize a salary for supervision. But when asked on Feb. 10, 1953, at a meeting of the membership committee of the society what his present income from the hospital was, Dr. Mousel flatly refused to give the information and said that even though advised by his counsel he would not do so. This question was asked to determine if he and the hospital were doing indirectly (that is, making up by salary Dr. Mousel's loss of percentage of departmental income through a change in his contract) what he could not do directly, *i.e.* receive a percentage of departmental income for the practice of medicine. . . . Although this violated the society by-laws that an applicant must furnish pertinent information or his application will be held in abeyance until he does, the society proceeded with the processing of his application in a fair-minded, conscientious endeavor to reconcile all differences."

WERE VOTERS INFORMED?

At the time this brief was presented and considered, it should be noted, the 1950 Hess Report referred to had been succeeded by two additional policy statements approved by the A.M.A. House of Delegates, the "Guides" statement of 1951 and the joint A.M.A.-A.H.A. report approved in 1953. Under the policies laid down in these statements, and the A.M.A. Principles of Medical Ethics, the only basis on which Dr. Mousel's arrangement with the hospital could be considered unethical would be a specific finding of fact that he was being "exploited" for the benefit of the hospital. No such charge was made before the Judicial Council, however, and in its deliberations, apparently, the council restricted its consideration to the single question of whether or not the membership vote had been properly conducted.

While the Judicial Council took no specific exception to the manner in which the elections had been conducted, a question was raised in the council about the extent to which the membership had been informed of the May 1953 agreement under which

(*Continued on Page* 140)

Hospital Statistics Don't Tell the Truth

ROBERT S. MYERS, M.D.

Assistant Director
American College of Surgeons

SINCE July 1953 the American College of Surgeons, aided by a grant from the W. K. Kellogg Foundation, has been engaged in a research project designed to develop a practicable medical audit. As a background for this project, the orthodox methods used by hospitals to assess the quality of patient care have been examined and have been found to be deficient. This revelation will surprise few people familiar with hospital practice, but it will startle many to learn that the hallowed statistics which have been used by hospitals for many years as indices of adequate patient care are antiquated, usually meaningless, often illogical and frequently unscientific. Such statistics serve only to dull the keen edge of our medical conscience and to lull us into a false sense of accomplishment. It would seem that hospitals are the only major business in which unreliable statistics are thoughtlessly selected, laboriously collected, promiscuously dissected, and unreservedly accepted as facts which accurately gauge achievements.

These are serious charges, but they are made on the basis of the following statistical usages which are standard operating procedure for hospitals:

1. The use of the terms "recovered" or "improved" or "unimproved" to describe the discharge status of a patient is not logical. In the first place, the "condition on discharge" is based on an impression of the status of a convalescent patient, and insufficient time has elapsed to permit evaluation of his treatment and condition. It is not known whether he is "recovered" or "improved" or "unimproved" at the time of discharge. Secondly, few patients seem to leave a hospital "unimproved." This could be a tribute to the care given by the medical profession and our hospitals, but is probably chargeable to the vagaries of human nature. It is more popular to have an "improved" patient. Actually, a patient leaves a hospital in one of two ways, alive or dead. Any other classification is sheer whimsy.

2. Our "final diagnoses" are often not exact. Symptom diagnoses are still too frequently made and euphemisms are not uncommonly employed to conceal the true nature of the patient's illness. It would be most interesting if we knew the total number of normal appendices in this country which are signed out as "acute appendicitis," "chronic appendicitis," "acute-chronic appendicitis" and other subterfuges. This, however, we have no way of knowing at present. As a matter of fact, we do not even know the total number of appendectomies performed in the United States annually, and this in a country which prides itself on knowing how many automobiles and how many cans of soup are manufactured yearly.

3. We ask for details of patient admissions, discharges, per cent of occupancy and average daily census and place great value in such statistical data. What does it tell us? Very little. What we should be interested in knowing are such details as the age, sex, length of stay and the type of payment for specific types of diseases and operations.

4. We point with pride to a net death rate of less than 4 per cent and to a postoperative death rate of less than 1 per cent. But we obtain a meaningless net death rate by dividing all deaths over 48 hours by the total num-

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The articles on the following pages, describing the Professional Activity Study of the Southwestern Michigan Hospital Council, are condensed and edited from the transcript of a symposium presented at the 24th annual Tri-State Hospital Assembly. Participants in the symposium were: Dr. Robert S. Myers, assistant director, American College of Surgeons; Dr. Vergil N. Slee, director of the Professional Activity Study for the Southwestern Michigan Hospital Council and administrator of the Barry County Health Center, Hastings, Mich.; Dr. H. R. Mooi, obstetrician and member of the medical staff of the Community Health Center at Coldwater, Mich.; Dr. Bert Van Der Kolk, radiologist at Pennock Hospital, Hastings, Mich.; Robert G. Hoffmann, statistician for the Professional Activity Study; Mrs. Viola Farr, medical record librarian at the Community Hospital, Battle Creek, Mich., and president of the Southwestern Michigan Association of Medical Record Librarians; William Erickson, administrator of the Three Rivers Hospital at Three Rivers, Mich., and Dr. C. Wesley Eisele, associate professor of medicine at the University of Colorado School of Medicine, Denver, who has done medical audits for some of the hospitals in this study.

Dr. Robert S. Myers

Dr. Vergil N. Slee

Dr. B. Van Der Kolk

Robert G. Hoffmann

William Erickson

Dr. C. W. Eisele

ber of discharges. Why 48 hours? Why not 12 hours, or why not all deaths occurring after the patient is admitted to the hospital? We delude ourselves with a 1 per cent postoperative death rate, for this is obtained by dividing all deaths within 10 days of operation by the total number of operations. It makes little sense to divide deaths following operations for brain tumors and abdominal malignancies by dental extractions, hemorrhoidectomies and other operations from which the patient should recover. Moreover, why limit postoperative death to 10 days following operation? Medical science has advanced to the stage where life may now be prolonged for long periods after admission, or operation, and all deaths should be evaluated in any statistical method. Furthermore, deaths should be calculated in relation to a sperific disease or operation. To do less is to foster rates which are no index of adequate patient care.

5. We set a top limit of 3 to 4 per cent for cesarian sections and view with alarm any increase over this figure. Yet a review of the literature and inspection of cases from reliable and recognized obstetrical centers shows that, with justification, the rate now may be approaching 6 to 7 per cent. Cesarian sections are intended to facilitate the welfare of both the mother and the baby. Should we not be interested in knowing how many infants do not survive because the cesarian was too long delayed or because it was not done at all? We must revise our estimation of the justified cesarian section rate.

6. We speak of a rate of 1 per cent as the upper limit of justified postoperative infection and then are gratified that we have no infections, or very few at most, to report. It is true that modern medical science has means of preventing or reducing infection, but infections still occur after operation. With the use of antibiotics, justified in some cases and indiscriminately used in many others, combined with the use of early ambulation, the patient now leaves the hospital early and may well develop his wound infection at home. Such infections are rarely reported back to the hospital record.

7. We specify a desirable consultation rate at 15 to 20 per cent of patients treated in a hospital. Is this a valid figure? We do not know. What we should seek is a 100 per cent rate of recorded consultation in those cases in which consultation is required by the rules and regulations, as well as the highest possible percentage in those cases in which consultation is thought to be advisable.

8. We have claimed that less than 10 to 15 per cent normal tissue removal means adequate surgical performance, and have disregarded the evident fact that clinical indications for surgery, and not the tissue diagnosis made by the pathologist, justifies the surgery. Moreover, we now have figures which indicate that the percentage of normal tissue removal varies widely for justified surgery according to the organ removed. Thus the number of normal appendices removed justifiably in such conditions as ruptured ovarian follicle, mesentetic adenitis, and regional ileitis, where the differential diagnoses cannot be made with certainty, will be much higher than in the case of the gall bladder, since x-ray technics have brought a high degree of diagnostic accuracy in this condition. The truth is that a 10 to 15 per cent normal tissue rate for all tissue removed at operation is not an accurate rate or a reliable index of the quality of surgery. We must reevaluate surgical performance and place the emphasis on the percentage of justified surgery as determined for each case by the medical staff.

9. We ask for complications to be recorded on the chart and, not finding any recorded, assume that there are none. Complications are as poorly dictated and recorded as are postoperative infections. Many occur on all services of the hospital; few are listed.

10. Does it not seem strange that we do not even have an adequate definition of such conditions as an operative death, a postoperative death or an anesthetic death? It is little wonder that our statistics are so poor!

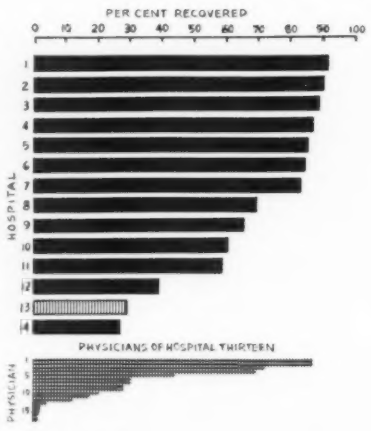
11. Finally, it should be apparent that the usual method of collecting, tabulating and analyzing hospital statistics by hand is not adequate for an industry as vital and extensive as hospitals. This is a machine age, and methods are available to provide hospitals and the medical profession with a relatively inexpensive efficient method for obtaining vital statistics. Moreover, there is a need for the pooling of accurate hospital statistics from individual hospitals, reporting by a standard method.

These statistical deficiencies are not the entire fault of American hospitals, nor can they be attributed solely to the agencies which have directed hospital standardization or accreditation. They are the result of the phenomenal growth of hospitals, which has outstripped the resources available for research, investigation and planning by all those interested in hospital patient care. The time has now come when certain fundamental aspects of patient hospital care must be reviewed and redefined.

The medical audit will not be practicable, except for exceedingly limited uses, until simple and inexpensive methods are widely employed by hospitals for the collection, tabulation and analysis of pertinent and fundamental data concerning the care of the patient, and until more meaningful indices of adequate practice are in use.

The American College of Surgeons has, under its medical audit program, investigated methods of professional service accounting. We have found, already in operation, a unique method devised by the Southwestern Michigan Hospital Council, also under a grant from the W. K. Kellogg Foundation. This method promises to fulfill the need for a practicable method of collecting, tabulating and analyzing data. The Professional Activity Study, as it is called, is also well along the way to providing for us much more realistic and useful indices of medical practice. We hope to complement this approach with the factor of medical judgment, and devise a practicable medical audit, and to this end the Southwestern Michigan Hospital Council project and that of the American College of Surgeons are in collaboration.

PER CENT OF PATIENTS WHO WERE REPORTED TO HAVE RECOVERED, BY HOSPITAL AND PHYSICIAN, 1953



Figs. 1 and 2

Statistics Influence Medical Practice

VERGIL N. SLEE, M.D.
Director, Professional Activity Study
Barry County Health Center, Hastings, Mich.

A FRIEND came to us one day and said, "One of the members of my family has to be hospitalized. How can I tell what hospital to put him in?"

We answered, "Professional services statistics are designed to give the answers to questions like that. We'll just see which hospital is the safest to go into, or in which you may expect the most dramatic results of treatment. We have 15 hospitals which have been contributing some data. Let's see which hospital reports the greatest percentage of recoveries on discharge."

You will notice that in Hospital No. 1, 92 per cent of the people recovered and in Hospital No. 14, only about 28 per cent recovered (Fig. 1 on opposite page).

So, we said, "Obviously, there isn't any sense in going to Hospital 14, you've only got a 1 in 4 chance of getting out of there cured."

Well, we wondered if our conclusions were justified, so we took No. 13 hospital (cross-hatched bar on chart) and looked at the performance of the individual doctors and we learned a very surprising thing. We learned that the 28 per cent recovery rate for the hospital had only a mathematical relation to what the individual doctors in that hospital were doing. One doctor was "curing" 85 per cent of his patients, and two doctors weren't curing any (Fig. 2). I think this illustrates what Dr. Myers mentioned about some of the statistics we have had to work with.

About four years ago we learned through Andrew Pattullo of the Kellogg Foundation that in Rochester, N.Y., an attempt was being made to make more sense out of hospital service statistics. We thought it sounded like a good idea and asked if the Foundation would help support such a study for us. A grant was obtained for a period of three years and we started to keep track of about 300 items of data that could be obtained from medical record rooms. A report was sent in at the end of each month to the council office by the medical record librarians, and we tried to analyze and compare these reports from 15 hospitals.

After collecting data from the 15 hospitals for some two years, it was found that the data being obtained were too voluminous to analyze by hand tabulations, and that many of the items varied from hospital to hospital because of local hospital policies. For these reasons, the valid comparisons we were able to make between hospitals were so few and so laborious that we concluded the project should be either abandoned or radically changed. So nearly two years ago, in the late summer of 1952, almost a year before the American College of Surgeons' medical audit project mentioned by Dr. Myers was started, we decided to attempt some changes in our study. One was to obtain the services of a statistician and the other was to obtain information on each individual hospital discharge, put this information on a punch card, and tabulate the resulting data by machine.

We approached the statistics department of the School of Public Health of the University of Michigan for assistance. It helped us with a small pilot run in November 1952, and offered to take us under its wing as to statistics and method on a research basis. We accepted the offer. The approach looked so promising that we got an increased grant for 1953. The hospitals in the project all went into the new system on Jan. 1, 1953. Much credit is due the librarians at these hospitals for making such a radical departure from established ways.

The study now has grown to the point where for 1954 and 1955, we have a sizable grant from the W. K. Kellogg Foundation, and I am spending full time with the project, inasmuch as the main problem is to find out how to make the data work. We have a tremendous wealth of information which we need in practicing medicine recorded in the medical records of our hospitals. It can either go to work for us or lie idle. We want it to go to work for us.

There are two methods of getting some idea of quality of medical care. The two approaches are not separate, but rather complement each other. First is medical service or professional service accounting and, second, the medical audit. The latter may be done by a medical auditor or it may be done by the medical staff itself. A new method for a staff itself to use is being developed in the American College of Surgeons' medical audit project. We are working with the College on this, and are conducting field trials in some of the hospitals in our hospital council and also furnishing statistical analyses. We can say that we are encouraged, but that is all we wish to report at the present time. The medical audit, as mentioned by Dr. Myers, has to be based on medical service accounting that can be depended on.

A SECOND PROBLEM

All administrators and medical record librarians are familiar with the usual form for compiling hospital statistics. It has the number of patients in medicine and surgery, deaths under and over 48 hours, and that sort of thing. What does such information mean? To make sense out of it, we have to compare it with something. Well, what can we compare it with? About all we have at the present time is what's in the books. We can compare it with that.

We think, however, that it is much better to be able to compare what's going on in a given hospital today with what's going on today in a number of comparable hospitals with comparable patients, rather than to

SOUTHWESTERN MICHIGAN HOSPITAL COUNCIL

PROFESSIONAL ACTIVITY STUDY CASE SUMMARY CODE SHEET** BATCH _____ PAGE _____

1. REPORTING HOSPITAL [ ][ ]

2. DATE OF DISCHARGE Month [ ][ ] Yr [ ]

3. ADMISSION NUMBER THIS ADMISSION [ ] UNIT NUMBER [ ][ ][ ][ ][ ][ ]

4. LENGTH OF STAY, DAYS Day of admission is a day, day of discharge is not [ ][ ][ ]

5. AGE ON ADMISSION Units: 1. Newborn 2. Year (year or over) 3. Months (over 27 days, under 1 yr.) 4. Days (27 days or less) 5. Years plus 100. Unit [ ] Age [ ][ ]

6. SEX [ ]
1. Male
2. Female
Incomplete Chart—
3. 7 Days or Less
4. Over 7 Days
5. Incomplete Chart—Data Not in

7. RACE [ ]
1. White
2. Non-White
3. Not Recorded
4. Negro
5. Latin American
6. Puerto Rican
7. Asiatic
8. Other

8. DISCHARGE STATUS [ ]
1. Discharged Alive
2. Died Over 48 Hrs.—Autopsy
3. Died Over 48 Hrs.—No Autopsy
4. Died Under 48 Hrs.—Autopsy
5. Died Under 48 Hrs.—No Autopsy
6. Stillborn—Autopsy
7. Stillborn—No Autopsy

9. PHYSICIAN ATTENDING Code Number Assigned by Hospital [ ][ ]

10. NUMBER OF DISCHARGE DIAGNOSES Enter Total Number of Different Disease States, NOT Manifestations [ ]

11. COMPLICATIONS Enter Total Number During Hospitalization [ ]

12. CONSULTATIONS Enter Total Number of Written Consultations [ ]

13a. Diagnosis Causing Admission * [ ][ ][ ][ ] – [ ][ ][ ][ ] • [ ]

13b. Second Diagnosis * [ ][ ][ ][ ] – [ ][ ][ ][ ] • [ ]

13c. Third Diagnosis * [ ][ ][ ][ ] – [ ][ ][ ][ ] • [ ]

13d. Fourth Diagnosis * [ ][ ][ ][ ] – [ ][ ][ ][ ] • [ ]

14. OPERATING SURGEON Code Number Assigned by Hospital [ ][ ]

15. ANESTHETIST Code Number Assigned by Hospital [ ][ ]

16. ANESTHESIA [ ]
1. Ether + O_2
2. Ether + O_2 & relaxant
3. N_2O + O_2
4. N_2O + O_2 & ether
5. N_2O + O_2 & relaxant
6. Vinethine or C_2H_3CL
7. Chloroform
8. Vinethine, C_2H_3CL, or Chloroform followed by N_2O or Ether, or both
9. Cyclopropane + O_2
A. Cyclopropane + relaxant
B. I.V.
C. I.V. + Ether + O_2
D. I.V. + Ether + relaxant
E. I.V. + N_2O + O_2
F. I.V. + N_2O + relaxant
G. I.V. & Loc.-reg. bloc
H. Rectal avertin
J. Rectal avertin + inhal.
K. Rectal avertin & inhal. + local or regional
L. Rectal pentothal
M. Rectal pentothal + other
N. Spinal
P. Spinal + I.V.
R. Spinal + other
S. Bloc or regional
T. Local
U. Refrigeration
W. Relaxant + local or sed.
X. Trichlorethelene
Y. Others

17. NUMBER OF SURGICAL PROCEDURES Enter Total Number During Hospitalization [ ]

18. TISSUE [ ]
1. Disease
2. No Disease
3. Tissue Not Sent
4. No Tissue Removed

19a. First Operation * [ ][ ][ ][ ] – [ ][ ]

19b. Second Operation * [ ][ ][ ][ ] – [ ][ ]

19c. Third Operation * [ ][ ][ ][ ] – [ ][ ]

19d. Fourth Operation * [ ][ ][ ][ ] – [ ][ ]

20. X-RAY STUDIES A [ ] B [ ]
A—
1. Chest
2. For Fractures
3. Extremities (other than fractures)
4. Gastro-Intestinal
5. Gall Bladder
6. G-I Plus G. B.
7. Uro-Genital
8. Any Combination 1 to 7
9. Repeat Exams for Re-evaluation
X. All Others
B— Total Number of X-Ray Exams

21. URINALYSIS [ ]
1. Routine -s Microscopic
2. Routine -c Microscopic
3. Routine plus Fat
4. Routine plus Blood
5. Routine plus PSP, DIL, Conc.
6. Routine plus Repeat Sugars
7. Routine plus Bile and/or Urobilinogen
8. Routine plus 17 Keto Steroids
9. Routine plus Other Special Studies
X. Routine plus 2 or More Special Studies

22. HEMATOLOGY [ ]
1. Bleeding and/or Coag. Time
2. Hemoglobin (RBC not done)
3. RBC (with or without HGB)
4. Hematocrit
5. WBC
6. CBC Including Differential
7. CBC plus Sed. Rate (or sed. rate only)
8. CBC plus Hematocrit
9. CBC plus Other Special Tests
X. Bone Marrow (CBC implied)

23. SEROLOGY [ ]
1. Kahn
2. Kahn plus Rh
3. Special Human Antibodies
4. Bacterial Agglutination
5. Heterophile
6. Quantitative Kahn
7. Kahn plus 2 or More from Above

24. TOTAL NUMBER OF LAB PROCEDURES [ ][ ]

25. CHEMISTRY [ ]
1. Sugar
2. Nitrogen Derivatives
3. Total Proteins -c or -s A/G Ratio
4. Prothrombin Time
5. Cholesterol -c or -s Esters
6. Liver Function Tests
7. Electrolytes
8. Amylase, Vitamins, Others
9. Tests from 2 Groups Above
X. Tests from 3 or More Groups Above

26. Gastric-Stool [ ]
1. Gastric or Vomitus for Blood
2. Stool for Blood
3. Stool for Fat or Trypsin
4. Stool—OVA plus Parasites
5. Stool—Bile and/or Pigments
6. Gastric—Fractional as for HCl
7. Sputum—Other Than Bacteria
8. Both Gastric and Stool

27. Bacteriology [ ]
1. Direct Smear Only
2. Smear and Culture
3. Sub-Cultures for Identification
4. Anti-Biotic Sensitivity
5. Animal Inoculation
6. Sent Away for Study
7. Blood Culture
8. Skin Tests for Allergy
9. Skin Tests and Bacterial Studies

28. Tissues/Toxicology [ ]
1. Gross Exam Only
2. Papanicolaou
3. Microscopic Exam
4. Microscopic plus Special Stain
5. Frozen Section plus Routine Microscopic
6. Alcohol
7. Chem. Studies—Sedatives, Poisons
8. Toxins plus Tissues

29. SPINAL FLUID [ ]
1. Cell Count Only
2. Pandy or Other Protein
3. Routine incl. Count, Sugar, Protein
4. Kahn and/or Colloidal Gold
5. Others

30. EKG—BMR [ ]
1. EKG
2. EKG—2 or More Exams
3. EKG with Special Leads
4. BMR
5. BMR—2 or More Exams
6. BMR—Special Circumstances
7. EKG plus BMR
8. Electroencephalogram
9. EEG and/or BMR, EKG

31. BLOOD A [ ] [ ]
A—
Enter Number Whole Blood Transfusions 500 ml. Each or Less
B—REACTIONS
1. None Recorded
2. Recorded as none
3. Subjective
4. Allergic -c Rash
5. Pyogenic
6. Mistaken in Type plus X-Match
7. Due to Frequent or Many

32. PAYMENT [ ]
1. Private
2. Commercial Ins.
3. Workmens Comp.
4. Blue Cross
5. Local Welfare
6. Veterans
7. Crippled Children
8. Charities
9. Other

REMARKS:

FOR SPECIAL STUDIES 33. [ ][ ]

*CODED BY STANDARD NOMENCLATURE

Form No. SWMHC-100—1-54

Fig. 3—Professional Activity Study Summary Code Sheet

compare it with yesterday in some possibly very different situation.

I have already discussed the "recovered rate." Hospital service assignment is another problem. Consider the situation with burns. It has been my experience that any time that two medical record librarians get together, they have an argument as to whether burns are surgery or medicine. There are many similar conditions in which the practice of medical records keeping

is not well standardized. Now such situations can be ironed out. We can make rules and follow them. But it is not as simple as that. For instance, some hospitals take the approach that service assignment depends upon the doctor attending the patient. If the doctor is assigned to the medical service, any patient he brings in is automatically assigned to the medical service. I am not going to debate whether service assignment should be made on the basis of the physician or the diagnosis. The point is that one can't compare hospital statistics by service assignment unless all hospitals use the same method.

A third problem has to do with such items as minor and major operations. We have sought in vain for definitions, and we don't use this subdivision any more. The only method that we ever thought made any sense was the suggestion: Use the Blue Shield book which codes all the operations and assigns a fee for the doctor for each one. Select a fee, such as $25, and make a rule that all cases for which the fee is above that level are major surgery, and those for which the fee is below that level are minor surgery. I think that is pretty good because it will work. It is practical.

Now suppose we want to get rid of some of these problems. There are several requirements that a system must have if it is going to help us produce useful statistics. First, we must have uniform basic data, which means that the words mean the same thing in every hospital and in every case without any shifting around of the definitions. These data also must be accurate. There must not be any mistakes that we can reasonably expect to keep out. Second, this material must be available for analysis. We'll go into a little more detail about what we mean by that later. Data are not really available for analysis in those hospitals in which someone runs a line across a discharge book for each patient, foots each page, and brings the footings forward at the end of the month. Third, they must be statistically correct. Finally, they must measure medical practice. We are not interested at this time in measuring how medical record rooms work. We are trying to get right to the core and talk about medical practice, and as little else as possible.

Data for medical accounting must be either objective or subjective. By objective data, we mean information which can be copied or recorded directly from the medical record by the librarian or a clerk without the exercise of interpretation or medical judgment. By subjective data, we mean those which are the product of the application of expert medical judgment. Either one is all right. But, an attempt to compare any data which are mixtures of the two results in trouble. Specific items must always be prepared by one or the other method, not by both.

In our hospitals the medical record is completed, the diagnoses and operations are coded, and the record is made ready for filing exactly as in any hospital. At this point we depart from the usual practice. The medical record librarian now completes a code sheet (Fig. 3) which is currently in its third or fourth revision and is again being revised, since we are planning to try disease indexing with the International Classification. This sheet is filled out by the librarian on each patient discharged.

We added the information on laboratory, x-ray, diagnostic procedures, payment, and so on, not because we knew what we could find out, but because we knew we could obtain accurate data of this sort from charts and had a hunch that it would have meaning. We are not dealing with "How high was the white count?" but with "Was one done or not?" Was a blood transfusion given or not, was a urinalysis done or was it not done? We found that our hunch was right.

HOW THE SYSTEM WORKS

These code sheets are sent in to Ann Arbor, where the School of Public Health is furnishing machine services. Dr. Hoffmann takes over. He has a key punch operator and a machine operator and they go to work turning this sheet into a punch card. When the librarian tells us that the data are all in for a given month, we take all the cards for the particular hospital for that month and run them through the machines and send certain information back to the hospital.

First is the service assignment breakdown and other information on patients under 14 years of age. Other information by services includes number of discharges, days of stay, operations, autopsy, total laboratory and total x-ray procedures. Some of that may not seem too useful, but some of it does have meaning and the machine would just as soon print a whole line as a part of a line so actually we are getting it for nothing.

On another form we report service assignments in the "over 14" age group. The librarian in the individual hospital does not make any service assignments. They are all made on the basis of diagnosis at one point. And now we know that we can compare it.

A third report also comes back to the hospital, and this is just a simple analysis on the basis of who pays the bill: private, commercial insurance, workmen's compensation, Blue Cross, local welfare, veterans, crippled children, charities and other. Administrators, and in our experience, medical staffs, find this quite interesting.

In addition, three indexes are returned to the hospital at the end of each month. One of these is in sequence by operation. The second index is by diagnosis, and the third sheet is a listing of deaths for the hospital for the month. These indexes carry all the information which was on the original code sheet that the librarian sent to the center. It is all printed in the index listing.

At the end of six months, we print a final indexing for each record room. We index by disease, by operations, by physician by disease, and by physician by operation. That makes four indexes, and many of our hospitals have never been able to afford even a disease index before. Another service we render is to provide duplicate copies of the physician indexes and give each doctor his own set. (Many physicians find this is useful, to most of them it is impressive. Some find it only baffling or just plain silly.)

Now, we have the routine work done, we've produced the indexes, and we've produced the monthly service analysis that every hospital has to have to be accredited. But as far as we are concerned, that is elementary, and now the fun really begins, because we have the data still on punch cards on a case basis. They are readily available for any kind of analysis that we see fit to make. The data we are now studying cover all discharges on 12 hospitals for all of 1953, and for three more for parts of 1953, a total of about 50,000 discharges to study for 1953. For 1954 there will be the full year for 15 hospitals, or about 80,000 discharges. Some ways in which this handling with punch cards can be useful are shown in the form of charts.

A COMPARISON OF AUTOPSY PER CENTS, BY HOSPITAL, 1953

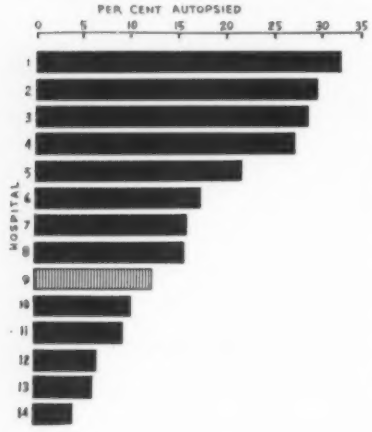


Fig. 4

For example, one of these is a fundamental and simple comparison of autopsy percentages by hospital (Fig. 4). The rates run from 33 per cent down to about 5 per cent. The "cross-hatch" hospital is the hospital which was numbered 13 on the first chart. It was also cross-hatched there. We are carrying this cross-hatching through the slides to show how the performance of a hospital varies in comparison with others, depending on what we are looking at.

Figure 5 shows the "per cent of appendectomies for whom chronic appendicitis was reported as a final diagnosis by hospital, for the year of 1953." The total number of appendectomies included in the study was 1555. Twenty-three per cent of the appendectomies in the hospital have the final diagnosis reported as chronic appendicitis. The hospital at the top had about 5 per cent reported for chronic appendicitis. The hospital at the bottom reported that 66 per cent of the appendectomies carried the diagnosis of chronic appendicitis. One other fact is worthy of comment: Hospital No. 1 in this group has probably the most active tissue committee —one that really scrutinizes surgery and appendectomies.

Figure 6 shows the same data, only in this case we studied the records of doctors who had done five or more appendectomies each, and computed the per cent of appendectomies reported for chronic appendicitis, by physician.

This analysis indicates some twenty doctors for whom it was not reported that a single appendectomy was done for chronic appendicitis. On the other hand, Doctor No. 96, down on the bottom line, was reported as having done 80 per cent of his appendectomies for a diagnosis of chronic appendicitis. Note the cross-hatched lines. We took the individual doctors from the "marked" hospital, which was No. 5. One doctor in that hospital did not do any with the diagnosis of chronic appendicitis, while one doctor ran around 63 per cent for chronic appendicitis.

I would like to add two or three things in summary: First, we think that quality control is a medical staff problem. Most doctors are sincere, earnest people who want to do their

PER CENT OF APPENDECTOMIES FOR WHOM CHRONIC APPENDICITIS WAS REPORTED AS A FINAL DIAGNOSIS, BY HOSPITAL, 1953

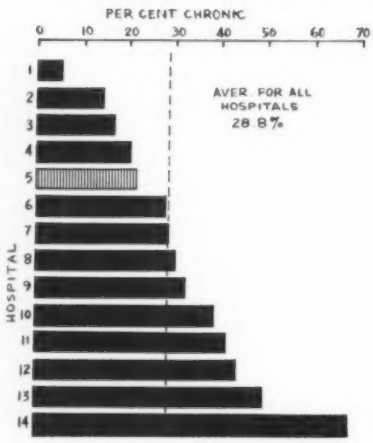


Fig. 5

best and constantly improve. In the past they have been handicapped by not having information in an available form, so that they could use it to guide them in what they were doing, either as individuals or as medical staffs.

The second thing is that statistics themselves are simply facts. One may make a comparison between laboratory data and statistical data. When variations from the usual findings appear, they simply indicate areas for further study. That is highly important. Rarely do such data of themselves make a diagnosis or determine treatment, if we wish to use the laboratory comparison. A blood count of 15,000, of itself, does not tell a doctor whether the patient has appendicitis or a myocardial infarction or an infection of the toe. Nobody expects it to. It is simply a fact which helps the doctor know what direction to take.

The hospital statistical service serves the medical staff in the same way that a laboratory serves a physician. Both the laboratory and the hospital statistical service provide reports. From the laboratory they go to the physician, from the statistical service they go to the medical staff. Now in each case the appropriate person or body interprets the data and uses them as a guide. In the individual case it goes into the treatment. From the staff standpoint, medical statistics influence medical practice.

It appears to us that the furnishing of hospital statistical service is going to be a logical function of the medical record librarian. It is going to be possible to reduce considerably the amount of drudgery and laborious work she now has to do. We think hand-made disease and operations indexes and hand-compiled statistics are on their way out. With the introduction of a system which makes data really available, and a mechanism for comparison among hosiptals and physicians, a new and useful tool is ready to be used. Record librarians can become the key figure in the hospital statistical service and provide vitally important information to the medical staffs of their hospitals, becoming indispensable members of the "quality control" activity. Medical staffs now can, in a much better way than ever before, use facts to help them guide the practice in the hospital.

PER CENT OF APPENDECTOMIES REPORTED FOR CHRONIC APPENDICITIS, BY PHYSICIAN, 1953

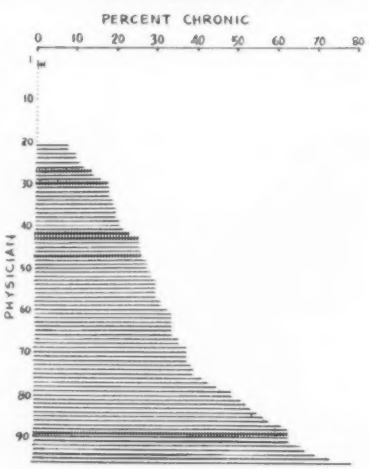


Fig. 6

Doctors Do Take Records Seriously

H. R. MOOI, M.D.
Obstetrician and Staff Member
Community Health Center, Coldwater, Mich.

MOST staff physicians are interested in records, although medical librarians feel that they are not be-

COMPARISON OF THE USE OF FORCEPS AMONG FOUR HOSPITALS, 1953

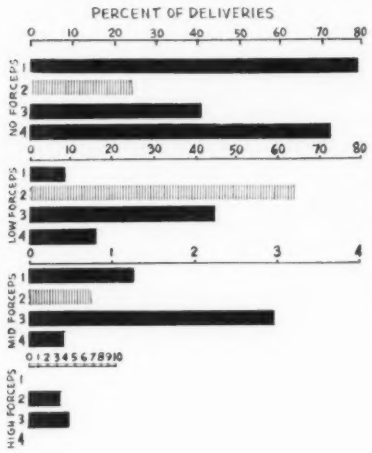


Fig. 7

cause of the tremendous problem of getting records finished, getting discharge diagnoses so they can be sent in to the insurance companies, getting the progress notes finished and death certificates signed, and all the little details which the doctors seem to abhor—and they do. Still, I have proved to my own satisfaction that nearly all physicians are proud of what they are doing, and conscientious enough to do their share.

If a doctor is interested in his records and is willing to compare them, and then is willing to look at the summaries that are presented to him, he knows that in some measure he is answering the criticism that is directed at doctors by the public in general. Doctors are criticized for being mercenary, for being selfish, and for being bigoted, but, still, when we present our findings to the doctors, it is apparent that practically all of them are interested in answering the criticisms that are made of them. They can study these statistics and know whether they are doing the best they can.

I believe that the hospital that studies its own records will improve and eventually such studies will eliminate some of the errors now being made in the fields studied. These studies will surely obtain recognition for the doctors who made them. The community that knows its doctors are studying their own methods, as well as the methods of others, and criticising them, is going to recognize the efforts of these doctors and is going to respect them for it. Finally, of course, the hospital is going to be recognized by the accrediting agencies.

Figure 7 is a comparison of the deliveries in four of these hospitals by the percentage of cases in which forceps were used. I'm not sure if all these four hospitals have the same concept of delivery by high forceps. The chart shows that in the first hospital 90 per cent of the patients were delivered without any kind of interference, less than 10 per cent by low forceps, a little more than 1 per cent by mid-forceps. It should be noted that the scale here is markedly changed. Even though it looks like a much longer line, the percentage by mid-forceps is still much smaller. There were none done by high forceps. (*Cont. on p. 60*)

NORMAL DELIVERIES FOR EACH PHYSICIAN, BY AVERAGE LENGTH OF STAY AND PER CENT FOR WHOM SURGERY WAS REPORTED, 1953

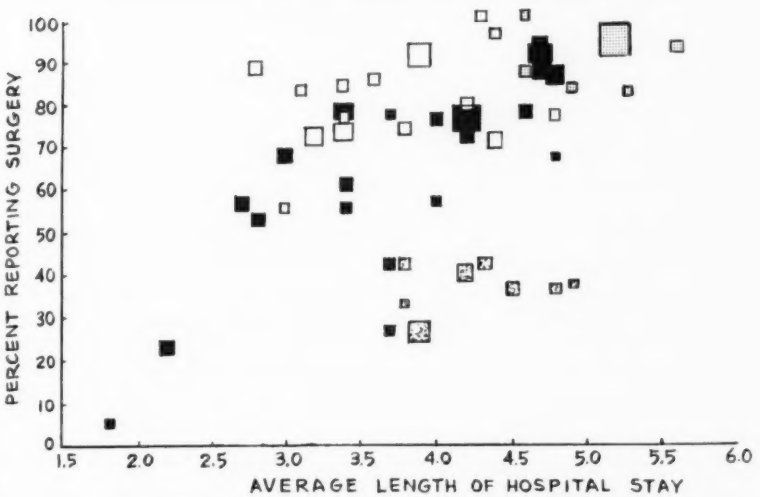


Fig. 8—The size of the square represents approximately the number of deliveries a particular doctor performed. No doctor with fewer than 10 deliveries is listed on the chart.

My first comment would be that any hospital which did 90 per cent of its deliveries without any forceps could not be expected to do any high forceps deliveries. The second line, representing the same hospital identified in the other charts, shows that that hospital did about 25 per cent of the deliveries without any forceps, approximately 75 per cent with low forceps, about two-thirds of 1 per cent by mid-forceps, and three-tenths of 1 per cent by high forceps. High forceps actually represents only one delivery. The third hospital had 41 per cent of its deliveries with no forceps, around 55 per cent with low forceps, 3 per cent with mid-forceps, and again four-tenths of 1 per cent by high forceps. The fourth hospital shows 84 per cent deliveries with no forceps, 16 per cent with low, half of 1 per cent with mid-forceps, and none with high. There is little difference in the number of deliveries in these four hospitals. I think it would probably develop that the hospital which had most of its deliveries without interference, if you want to call it that, also does not have anyone who limits himself to obstetrics.

Figure 8 represents normal deliveries with the percentage of deliveries for which some surgical procedure is done, either a forceps delivery or an episiotomy, charted against the length of hospital stay starting with one and a half days, by physician. The size of the square represents approximately the number of deliveries that a particular doctor performed. No doctor with fewer than 10 deliveries is listed on the chart. The unbelievable thing to me, however, is that there was one physician who actually had an average hospital stay for his patients of less than two days. It is also noted that that same physician had practically no forceps or episiotomy deliveries. In contrast to that, some of the doctors who did the most deliveries also did a much higher percentage of forceps deliveries and episiotomies and their patients also stayed a longer time.

Figure 9 represents the group of doctors practicing in one hospital. The experience varies from the low by one physician of 1.8 days' stay with about 5 per cent episiotomies or forceps deliveries to one physician who did 93 per cent of his deliveries with either forceps or episiotomies and his patients stayed around 4.7 days.

Figure 10 shows another hospital (the hospital identified in all the charts) which had an average hospital stay of five days with around 90 per cent interference.

NORMAL DELIVERIES FOR EACH PHYSICIAN, BY AVERAGE LENGTH OF STAY AND PER CENT FOR WHOM SURGERY WAS REPORTED, 1953

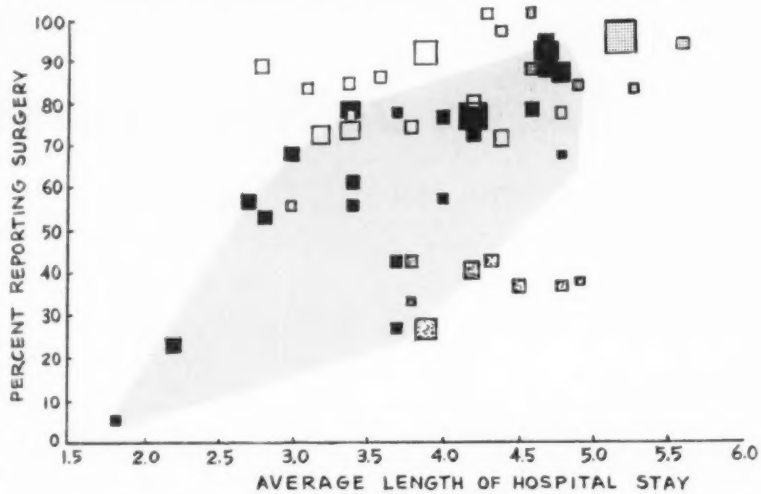


Fig. 9—The color overlay shows the length of obstetrical patient stay for a group of doctors at one hospital. It varies from a low of 1.8 days' stay with about 5 per cent interference to another doctor's patient stays of 4.7 days with 93 per cent of his deliveries either by forceps or episiotomies.

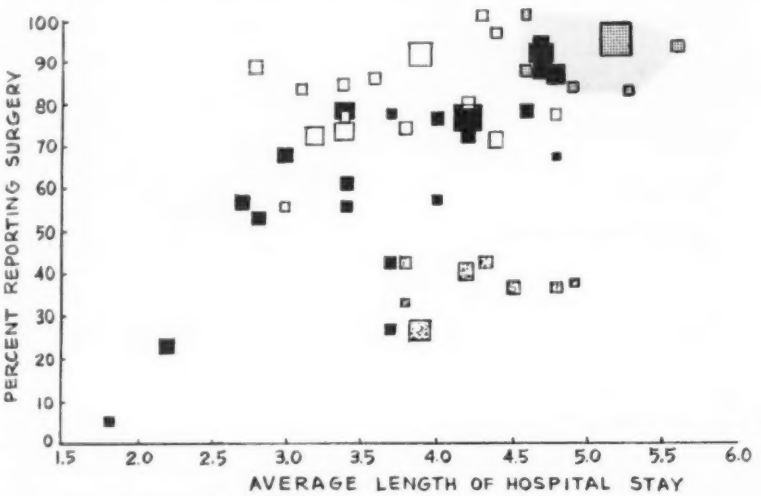


Fig. 10—A second hospital had an average obstetrical stay of five days with 90 per cent interference.

Figure 11 shows a little larger area. In other words, the thinking of these doctors is a little less uniform, although these doctors believe generally in a rather high percentage of deliveries with some sort of help.

Figure 12 is the fourth hospital. There is a lower incidence of episiotomies and forceps but it will be noticed that in this hospital, also, the doctors stick together. They have come to accept a similar procedure, which is much different from that of the others.

The only conclusion I can draw from these charts is that the doctors in the hospitals shown in Figures 10, 11 and 12 do have a similar feeling. Apparently, they are getting together and comparing notes. They seem to be in rather close agreement as to what is the proper method for handling obstetrics. Figure 9, however, is rather puzzling. It is the largest hospital and has the largest number of qualified obstetricians, yet it has very marked

NORMAL DELIVERIES FOR EACH PHYSICIAN, BY AVERAGE LENGTH OF STAY AND PER CENT FOR WHOM SURGERY WAS REPORTED, 1953

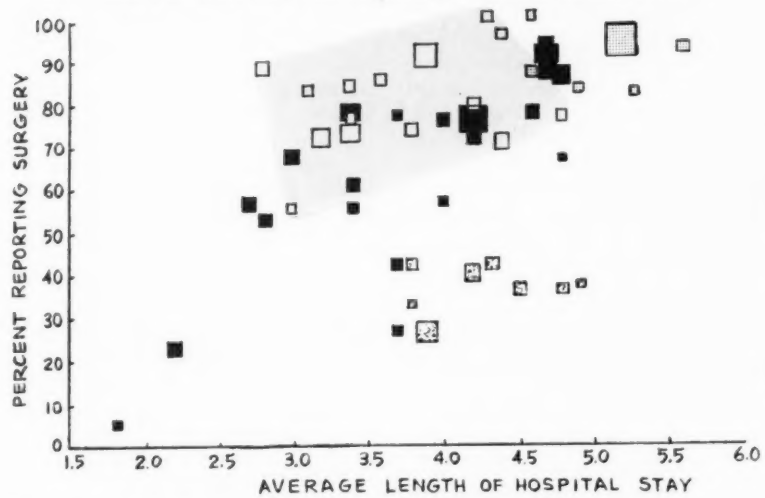


Fig. 11—Thinking here is a little less uniform, although doctors believe generally in a fairly high percentage of deliveries with some sort of help.

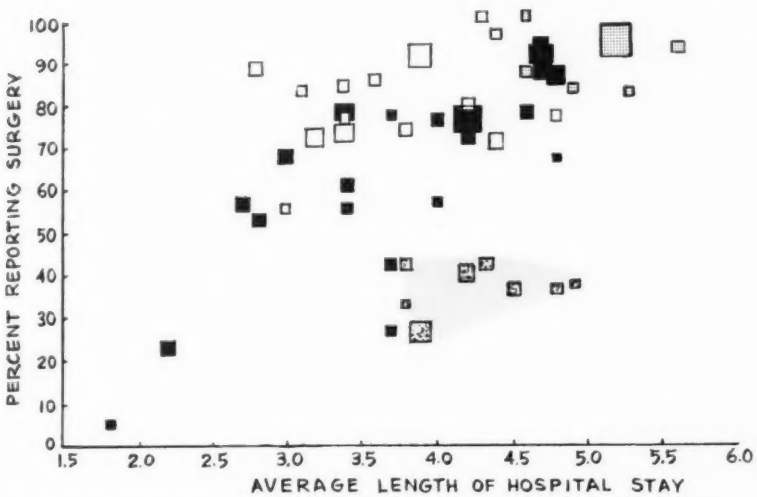


Fig. 12—In the fourth hospital, there is a lower incidence of interference although it will be noticed that these doctors, also, stick together.

divergence in the methods by which obstetrics is handled. The hospital which had the longest average hospital stay, I happen to know, has enough beds to take care of its obstetrics cases at all times so that the patients are not hurried home. That might be one reason the patients stay longer. It also might be that most of the deliveries in that hospital are done by one individual who is influenced by the fact that large maternity hospitals seem to keep their patients a longer time.

These charts do show what interesting facts can be gathered. I have asked Dr. Slee for these charts to take back to my own staff, and we'll have some big discussions over them. Particularly, will we take up the earlier chart in which it is shown that approximately 63 per cent of the appendectomies performed by one of our physicians were done for chronic appendicitis. It is my opinion that the physician who performs a very low percentage of operations for chronic appendicitis is a much more respectable surgeon than one whose percentage is so high. I may not be able to convince the latter, but this is the point at which the end result is going to come.

We must ask the Right Questions to get the Right Answers

ROBERT G. HOFFMANN
Statistician
Professional Activity Study

STATISTICAL methods may be described by the following four steps:

First, you must ask a question.

Second, you collect some information that is *relevant* to the question.

Third, you compare the information with the question.

Fourth, you decide what should be done next, with the new information that you now have—you ask yourself another question.

As an illustration of the method, consider the death rates mentioned by Dr. Myers. In this case, the question might be, "Is the gross death rate in our hospital within satisfactory limits?" The information relevant to this question would be the total number of deaths divided by the total number of discharges for a given period of time. The satisfactory limit, according to the textbooks, is 4 per cent, and if your death rate was below this figure, you might decide that nothing further need be done. This example illustrates the general method used in statistics, and it also illustrates the manner in which statistics are used in many of our hospitals. There are, however, some subtle aspects of the statistical method which this illustration conceals.

Why should anyone want to know whether the death rate was within satisfactory limits? The implication is that the rate and the satisfactory

limit are relevant information to the quality of care given to the critically ill patients. This may not be the case. For example, if most of the deaths that occurred in a hospital were deaths following tonsillectomy, the crude death rate might easily be within 4 per cent, but some practices would certainly need investigation. The trouble with this example is that the rate was compared with an accepted standard, and no consideration was given to the patients who were included in computing the rate.

Note how the question was worded: "Is the gross death rate in our hospital within satisfactory limits?" The wording of the question implies that a gross death rate will have to be computed, and as far as most hospitals are concerned, the comparison will be made with a rate published in a textbook.

In other words, the course of action followed by the individual concerned is largely determined by the way in which the question is phrased. Consider how different would be the course of action if this question were asked, "Was there any way in which the deaths that occurred in our hospital could have been prevented?"

Please do not misconstrue what I am trying to say. Crude rates of many kinds are quite useful, but one should never try to reach conclusions from crude figures that need refined information. For questions that are of critical importance to many persons, the most detailed information and careful analysis are often none too satisfactory. On the other hand, a great deal of work spent on questions of minor importance is wasted effort.

In the Professional Activity Study, we are attempting to find indices which are relevant to the quality of care given to patients, indices which can be computed in a minimum amount of time. Although there is much work yet to be done, some useful comparisons are already available.

The statistics that are tabulated for hospitals are records of work that has been done in the past, but what is most important as far as medical care is concerned is the assurance that patients now being treated, and those to be treated in the future, will receive good care. The statistics should be aimed at the important areas of medical practice to ensure that all is well, with the possibility of further investigation if the need arises.

PROFESSIONAL ACTIVITY STUDY

Small Hospitals Benefit by the New Approach

WILLIAM ERICKSON
Administrator, Three Rivers Hospital
Three Rivers, Mich.

MEDICAL records are tremendously vulnerable in this business of accreditation. Also, accreditation, in the very near future, probably is to be a universality in hospitals. Therefore, certainly, all administrators should be most concerned in something which is so important to the institutions they represent. The reason that medical records are so completely vulnerable is that we cannot conceal anything. What actually happened must be recorded. Possibly on an inspection, housekeeping might be slightly below standard, and perhaps it would not be seen; the same possibility exists with the dietary and other departments, but medical records stand out, showing whatever was done for the patient.

The small hospital has never needed to make any apologies for the services it renders because it is small. Although the small hospital offers more limited services, within the scope of feasibility, the services offered must compare with those offered in hospitals of all sizes. In this respect a small hospital must maintain records that compare completely with the largest hospital. As the administrator of a small hospital, however, I have an additional problem in getting these records. If one could easily hire a registered record librarian, it would be easy to maintain the records, but it so happens that there are not enough registered librarians to go around. In the smaller communities, we have to settle for something less than the most desirable in terms of trained personnel, but we also want the records to be equal to those produced by the best trained personnel.

VALUE LIES IN REPORTS

This program has bridged this gap for us considerably. We have available in our hospital now what we feel are quite acceptable and dependable indexes of diseases and operations, and indexes by physicians. In addition, the manner in which these records are compiled has eliminated much of the drudgery of copying and recopying, which had been so much a part of indexing as it was commonly done in the past.

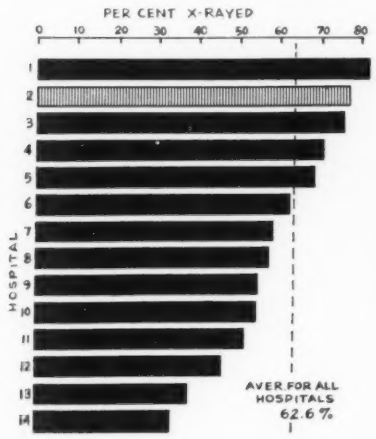
The statistics that are gathered take meaning only when they are worked into reports. The statistics of themselves mean very little, but as the reports that are produced are released, we have something of real value. These reports are particularly enhanced in their value because we have been able to compare ourselves with 14 other hospitals. A great competitive spirit is engendered in knowing how you stack up with someone else; this quality is exploited somewhat with the doctors by placing them in the position of knowing where they stand with other doctors. The comparisons do much to spur them on to greater achievements. We have never felt that reports that we get from this study should in any way be used as a "big stick." Rather, we should use the information we gain as an incentive to higher and better accomplishments. Many times the fact that we know that faults are present is enough to encourage the doctors to correct them. It seems quite appropriate to tell the doctors that they are doing a good job, as well as telling them that certain things need correcting.

These reports also provide, when necessary, some tangible facts which can be presented to a hospital board. Dependable and readily obtained statistics interpreted in results which can be compared to other similar hospitals give the hospital and the medical staff the fundamentals for the improvement of patient care.

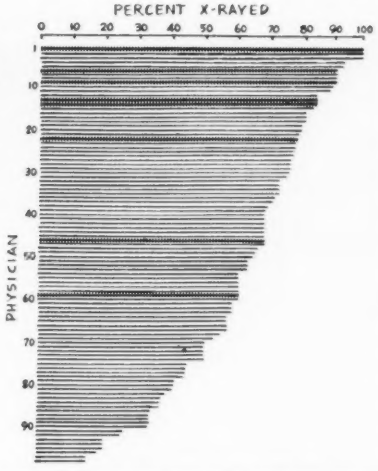
PROFESSIONAL ACTIVITY STUDY

Did They Have Pneumonia— or Didn't They?

BERT VAN DER KOLK, M.D.
Radiologist, Pennock Hospital
Hastings, Mich.



PER CENT OF PNEUMONIA DISCHARGES X-RAYED, BY HOSPITAL
Fig. 13



PER CENT OF PNEUMONIA DISCHARGES X-RAYED, BY PHYSICIAN
Fig. 14

FIGURE 13 shows the per cent of discharges with a primary diagnosis of "pneumonia" x-rayed, by hospital, and we see immediately that there is a tremendous difference from one hospital to another. One hospital in this study x-rayed more than 80 per cent of its patients who had pneumonia, and another hospital x-rayed something like 34 per cent.

In Figure 14, each line represents an individual doctor who treated five or more "pneumonias" in 1953. It will be noticed that there are some 97 doctors in 14 different hospitals, and a total of 1417 cases of pneumonia. The doctors from the "marked" hospital are again designated. Three of those doctors x-rayed every case of "pneumonia," but there was also a doctor who x-rayed only one in seven. Now, if you stop to think that this happened in 1953, in a hospital with x-ray service available 24 hours a day, you may find it a little bit difficult to believe. If you do, you are not alone. On the other hand, we cannot say that every patient who has pneumonia should have a chest x-ray, but when a man x-rays only one case of pneumonia in seven, you begin to wonder. I have my own idea of which one of these hospitals I'd like to be treated in.

PROFESSIONAL ACTIVITY STUDY

Record Librarian Lists Advantages

VIOLA FARR
Medical Record Librarian
Community Hospital, Battle Creek, Mich.

EVERY medical record librarian is vitally interested in anything that means progress, advancement and recognition for her hospital, but first she must be convinced that the undertaking, whatever it may be, will be worth the time and effort expended. As the practice of medicine becomes more advanced, medical record librarians find themselves burdened with more and more work.

Four of the main points of this study which are of particular interest to me, and I believe will be of interest to other medical record librarians, may be summarized here:

First, the code sheets which we prepare for each patient save time and work. When the code sheet for each discharge is completed, we have in one process taken care of our discharge analysis and the indexing by disease, operation and physician. In addition, we have also accounted for the number of complications, the number of consultations, the laboratory and x-ray examinations, both as to type and number, the anesthesia, the tissue, the number of blood transfusions and reactions, if any, as well as the manner in which the patient paid his bill.

At the end of each month we receive from Ann Arbor our discharge analysis and payment analysis, a listing of our deaths and autopsies, a disease listing, and an operation listing. The disease and operation listings are returned to us in topographical order with each doctor's cases being grouped together. Thus, at a glance we can tell any staff member the number of cases he has treated for any given period, as well as the type of disease and the end result. The disease, operation and physician indexes which are consolidated each six months are more complete than those we were able to keep previously, and have proved very useful in obtaining information requested by the medical staff and the administrator.

The code sheets can be prepared in less time than would ordinarily be consumed on the discharge analysis and the indexing of diseases and operations, while at the same time we are accumulating other statistics not ordinarily compiled in the record office. I feel, too, that uniformity of record room procedures and interpretation among hospitals is of value.

Second, many of our doctors are prompter in completing their charts than they were formerly. Thus we have fewer incomplete charts. I also note that, as the different statistical reports

are presented at staff meetings, our doctors are becoming more conscious of this study and are anxious to check themselves as to whether they are meeting the standards of good medical practice. More doctors are requesting statistical information now that they know it is readily available, without causing extra work for record office personnel. For example, in a matter of minutes, I was recently able to give to our chief of obstetrics and gynecology the number of abortions which required a dilatation and curettage during a certain period, along with the number of consultations on each, the consultations being his primary interest in this case. Ordinarily, this would have required the pulling of the charts to determine whether the proper consultations were held.

Third, inexperienced people can be taught to complete the code sheets, with a minimum of time and instruction, since we have a definite working manual. This is important in hospitals which are without a registered medical record librarian. In our own Southwestern Michigan group we have several such inexperienced people who have done a marvelous job on this project, and they deserve credit.

Fourth, I believe that the Professional Activity Study is giving us more and better statistics, in our hospital, than we would be able to compile by our old methods, in the same amount of time, and with the same number of employes. In many instances the pulling of charts is unnecessary to obtain the information requested, since the indexes we are getting give us much more information than we had. In these days of the shorter stay and the constant turnover of patients, any savings in time and labor are highly important if we are to have an efficiently run record department.

PROFESSIONAL ACTIVITY STUDY

Opinions Are No Basis

for an Objective Analysis

C. WESLEY EISELE, M.D.

Associate Professor of Medicine, University of Colorado

FOR several years, I had been interested in medical audit problems and had been working with the hospital division of the W. K. Kellogg Foundation where attempts were being made to devise new technics and yardsticks. In conjunction with these studies, I had performed medical audits in several of the hospitals now included in the Professional Activity Study. It was apparent that the usual type of medical audit suffers from several serious handicaps. The method is laborious and time consuming, and therefore expensive. The number of physicians who are able and willing to perform this type of audit is decidedly too small to make the method available to more than a handful of hospitals.

Perhaps the most serious handicap is that the usual medical audit consists largely of a collection of opinions of one individual, subject to all the inherent shortcomings of any opinion. It becomes highly important to distinguish opinion from fact if basic data are to be truly objective. Opinions may and do change. For example, a patient's record on which I render an opinion today in the form of a grade may be graded quite differently by another observer or even by me if I re-evaluate the same record next month, or next week. So a medical audit consisting of a collection of several hundred or thousand opinions of individual cases may be impressive, but it clearly lacks objectivity. A further handicap lies in the almost total lack of meaningful yardsticks for comparisons with data obtained in other hospitals.

In spite of these objections, medical audits have rendered notable service to those institutions where they have been used. Because they have stimulated the staff to take a good look at what they are doing and opened the way for free discussion, improvements in patient care have almost invariably followed. I recently had the opportunity to re-audit a hospital which I first studied three years previously. Using the number of primary appendectomies as a classic example, it was found that the 163 appendectomies performed during the year of the first study had shrunk to 100 at the time of the second study, and further decreased to 73 in the following year. General utilization of the hospital, on the other hand, had increased by 8 per cent during this period. Other areas of practice showed equally gratifying changes.

During the planning stages of the Professional Activity Study, I was frankly quite skeptical of the likelihood of a statistical method's successfully evaluating the quality of medical care, but I agreed that an adequate trial was warranted. After having the opportunity of periodically examining the masses of data becoming available through this study and by having participated in translating the statistical information into clinical meanings, however, my attitude has changed to one of enthusiasm. In my opinion, this approach holds promise of producing revolutionary changes in record room procedure; even now, in its infancy, it is providing new information which hospital staffs are finding useful in their endeavors to improve the medical care of the patient.

The studies which Dr. Van Der Kolk presented on pneumonia are of particular interest to me as an internist, for they represent one of our first effective attempts to evaluate medicine, rather than surgery only. Dr. Van Der Kolk, in his modesty as a radiologist, would not say that every patient with pneumonia deserves a chest x-ray. As an internist, I will go one step further —every patient with pneumonia should have at least two chest x-rays. One x-ray is required on admission to establish the diagnosis. Another is required before discharge to determine whether resolution has taken place and to be sure a more serious disease is not masquerading as an acute respiratory disease. "Pneumonia" may mean a host of different conditions, all of which may present very similar clinical pictures which may be quite indistinguishable on clinical grounds. Included in this group may be an acute tuberculosis, or the "pneumonia" may be the earliest manifestation of a cancer of the lung. Even though the acute symptoms have abated and the patient appears to be convalescent, without the follow-up chest x-ray, serious underlying diseases may go unrecognized until too late.

Kenneth B. Babcock, M.D.

The new director of the Accreditation Commission has been preparing himself for the job of hospital administrator ever since he was two years old

Doctor Babcock Moves From Grace

It wouldn't be Grace Hospital without a Babcock—but it won't be without a Babcock

DR. KENNETH B. BABCOCK, who takes office this month as director of the Joint Commission on Accreditation of Hospitals, may be the only hospital administrator in the country who started training for his job at the age of two years. Technically, Dr. Babcock has been a hospital administrator only since he became assistant director of the Grace Hospital, Detroit, in 1941, and his administrative career was interrupted by four years' service in the army medical corps, which he served as chief surgeon of a field hospital—largely a clinical assignment. Actually, however, Dr. Babcock has spent most of his 51 years not just in the hospital field, but, literally, in the hospital. His father, the late Dr. Warren L. Babcock, was administrator of Grace Hospital from 1904 until his retirement in 1938; the younger Dr. Babcock's professional education began at the age of two, when his family moved into a house that was across the street from Grace. It continued in the form of after-school and vacation chores at the hospital, through medical school, internship and residencies, and surgical practice, which he entered because his father thought an administrator should have the "taste" of private practice. Dr. Babcock's taste of medical practice turned out to be more lingering than he had anticipated; he started his practice with the intention of staying with it four or five years, then switching to administration. Instead, he stayed in practice 12 years, but he figures now that his effectiveness as an administrator was increased, rather than diminished, by the additional time he spent cutting and peering into the abdomens of hospital patients. "A physician is an individual, and a hospital is an organization," he said not long ago in an address at a hospital meeting. "It is the hospital administrator's job to integrate the individual into the organization by making it interesting for him and giving him a sense of pride in the organization." His training and practice as a surgeon, Dr. Babcock believes, has been "very, very helpful" to him in the performance of this difficult administrative task. He is a little irritated by the oft-quoted aphorism that "the hospital can't get along without the doctor, and the doctor can't get along without the hospital." In Dr. Babcock's view, this isn't true. "We couldn't," he says, speaking as a hospital administrator, "but they can." A recent study in New York City, he points out, revealed that 2500 doctors there had no hospital connections at all.

A man who started at the bottom, when he was still a schoolboy, by carrying milk cans up to the floor kitchens at 5 a.m., Dr. Babcock is familiar at first hand with every aspect of hospital operation. He has done it all himself, from running errands and checking supplies in the storeroom to autoclaving instruments in the operating room. His first administrative assignment when he became assistant director of the hospital in 1941 was to complete construction of a 400 bed

branch hospital on the outskirts of Detroit, 10 miles from the main 500 bed hospital downtown, and open it for patients. Like most seasoned hospital administrators, Dr. Babcock is equally at home with a blueprint, a balance sheet, and a disease index—but there is no question about which aspect of hospital administration he thinks is most important. "The hospital is not supposed to practice medicine," he said recently, "but it is the hospital's responsibility to the community to see that the best possible medicine is practiced within its doors."

NO "DOUBLE STANDARD"

As director of the Joint Commission, Dr. Babcock will dedicate himself to the improvement of medical practice in hospitals—and he means all hospitals. With his predecessor as commission director, Dr. Edwin L. Crosby, Dr. Babcock believes there can be no "double standard" for hospitals. For comparable services, he is convinced, the standards must be the same in small and large hospitals. "Accreditation should be the goal of every hospital," he said, adding that the desirability of accreditation has wide acceptance among hospital administrators and trustees but needs selling to doctors and the public.

"The commission has had a wonderful start under Dr. Crosby," Dr. Babcock remarked not long ago. "As I see it, we have two functions—to conduct the accreditation program itself, and to push the idea of hospital accreditation, especially with the medical profession and the public."

These objectives must be accomplished, Dr. Babcock believes, by showing hospital groups how to achieve self-improvement, and not by wielding the power of approval like a club. "Our commission has as its function and objective the desire to improve patient care and comfort," he said in an address to the Tri-State Hospital Assembly in Chicago this spring. "It is not a desire on the part of the participating organizations to be just a *Good Housekeeping* seal of approval and say, 'This is bad,' or 'This is good.' The organization is not a policeman. We want to raise our standards, and we think we can do it better ourselves than government can do it. We are spending $500,000 a year with the end result, we hope, of a satisfied, healthy individual and community and the finest standards possible in the hospitals of the United States and Canada."

Fine standards, in Dr. Babcock's view, must include ethical as well as professional considerations. A fellow of the American College of Surgeons himself, he approves the objectives of the College campaign against fee splitting, ghost surgery, and unjustified operations. Grace Hospital is cooperating wholeheartedly in the efforts of the Detroit Surgical Society to banish these evils locally, and Dr. Babcock believes that hospital administrators and boards elsewhere must concern themselves, in cooperation with their medical staffs, with ethical problems. He agrees with Dr. Crosby that an accredited hospital must promise its community an ethical, as well as competent, medical staff.

As director of the commission, Dr. Babcock will not conduct hospital inspections himself except under unusual circumstances. However, he is no stranger to inspections, having performed this function innumerable times as chief surgeon of the 15th Field Hospital, a unit that left San Francisco for Australia in 1942 and proceeded westward around the world, from Australia to Bombay to Suez to El Alamein, then across Africa and into Italy and Corsica with U.S. combat troops, taking part in five major engagements along the way. A tented hospital most of the time, the 15th set up shop once in a chateau on Corsica in the winter of 1943. "The rooms were too small, there was no plumbing, and it was difficult to get around in the building," Dr. Babcock recalls. "We were better off in tents."

"BEST REHABILITATION KNOWN"

The hospital varied in size from 400 to 1000 beds, depending on the needs of the moment, and Dr. Babcock, as chief surgeon, was responsible for procurement, records, and other administrative details, in addition to the operation of the surgical service. At the conclusion of the campaign in the Po Valley in Italy in 1945, he was awarded the Bronze Star for meritorious service in support of combat operations in North Africa, Corsica and Italy from June 1, 1943, to May 2, 1945. "Major Babcock established and efficiently operated a hospital in the Anglo-Egyptian Sudan and later skillfully directed hospitals in Libya, Corsica and Italy in climate and terrain varying from the blazing deserts of Africa to the cold, mountainous regions of Italy," the official War Department citation said.

Lt. Col. Babcock arrived home from the war on a Friday and went back to work at the hospital the following Monday. "This is the best rehabilitation known to medical science," he has declared. As it turned out, his father's successor as director of the hospital had died during the war, and *his* successor, though still on the job, was dying of cancer when Dr. Babcock returned. He served as acting director for one year, then became director on Jan. 7, 1947, thus, at the age of 44, taking over the job for which he had a lifetime of preparation. "I got an awful lot from Father by osmosis," Dr. Babcock says, acknowledging that his training was out of the ordinary.

Until a few weeks ago, Dr. Babcock expected to spend the rest of his life in the job for which he had so painstakingly groomed himself. Early in April, however, shortly after Dr. Crosby's appointment as executive director of the American Hospital Association was announced, Dr. Babcock was in New York attending a Blue Cross meeting when he got an urgent call from Dr. Crosby, saying that he and Dr. Newell Philpott of Montreal, commission chairman, wanted to see him. "They gave me a week to make up my mind," Dr. Babcock told an acquaintance recently, glancing regretfully around at the familiar surroundings of his comfortable office at Grace. "It was a hard decision to make."

Hard as it is for Dr. Babcock and his wife, who was surgical supervisor at Grace Hospital before they were married in 1928, to leave the hospital, their move does not leave Grace without a few Babcocks—and promise of more to come. Dr. Babcock's brother, Warren W., is a member of the surgical staff. His younger daughter, Patricia, is a student nurse at the University of Michigan now. Kenneth Jr. is a sophomore medical student at the university, and another son, Dwight, still an undergraduate, is pointed toward medical school. Like a poet in a family of bankers, an older daughter, Helen, lives with her husband in Florida and talks to doctors only when someone in the family is ill.

HEAD RULES HEART

As an administrator, Dr. Babcock has ruled by persuasion rather than edict, but he doesn't hesitate to say "No!" when he has to. The other day, for example, he came out flatfooted against allowing a student nurse with borderline grades to stay in school,

even though she was the daughter of a staff member. "Better to make the decision now and save trouble later on," he explained. But these are hard decisions, he acknowledged "—when your heart says one thing and your brain another." In the medical staff affairs that he considers all-important, however, Dr. Babcock leads by indirection, making certain that standing committees are working energetically at their regular tasks and, when necessary, seeing to it that *ad hoc* committees are organized to solve specific problems. "Dynamic committees mean a good functioning hospital," he once told a group of administrators, "but you must furnish the dynamite and light the fuse."

UNOBTRUSIVE IN LEADERSHIP

Dr. Babcock can't understand the kind of hospital administrator who takes a "You-run-your-show-and-I'll-run-mine" attitude toward the staff, or one who never goes to medical staff meetings. Active participation and leadership in medical staff matters, in his view, is the administrator's most important function. However, he has warned, this function must be performed unobtrusively. "You do most of the work yourself and give the committees credit," he has often told the administrative residents who worked with him at Grace Hospital. At staff meetings, he has added, the administrator should be on hand to greet staff members, call them by name and ask about their families and hobbies. "Make yourself both indispensable and liked," he sums it up, recommending a formula that could be expected to lead to success in almost any occupation.

In Dr. Babcock's case, at any rate, the formula works. Hiking with him through the corridors of Old Grace, whose main building is 65 years old and promises to outlive Babcocks of all ages, a visitor is impressed by the friendly exchanges with staff members that take place along the way; such a tour, in fact, is likely to become a succession of impromptu corridor conferences on staff matters.

Like members of the staff, Grace trustees, some of whom were active in the elder Dr. Babcock's administration, are appalled by Kenneth's departure. "We're all mad at him," said Edgar Guest, Detroit's homespun poet and an old-time Grace trustee, on a recent visit to the hospital. Obviously, however, Guest looks on Dr. Babcock with an affectionate mixture of pride and astonishment, as a parent might regard a child who can read and write Greek.

Administrators who know Dr. Babcock only at a distance—as a past president of the Michigan Hospital Association, for example, or as president of Michigan Blue Cross, or as a member of the national Blue Cross Commission, or the Commission on Financing Hospital Care—are likely to think he is somewhat austere. A big, balding man who looks a lot like Harold Stassen, the Mutual Security Administrator and erstwhile presidential candidate, Dr. Babcock is formal, and sometimes even severe in manner, when reading a paper or presiding at a meeting. Once in a while, he achieves a startling effect by departing from his prepared text or agenda, without changing the gravity of his tone, to tell a lively, or even earthy, story that sharpens up the point he is trying to make. Off the platform, he is informal and easily approachable, and he likes nothing better than to sit at luncheon in the staff dining room in the hospital, trading medical school anecdotes of the "My Old Professor" *genre* with staff members.

OPENS UP ON BLUE CROSS ABUSES

Usually, however, Dr. Babcock's conversation, with staff members and others, is predominantly serious and purposeful. One of the subjects that has engaged his earnest attention during the last two or three years, for example, is over-utilization of hospital facilities, especially by Blue Cross members, insured patients and their physicians. His paper on this subject at the Tri-State Hospital Assembly two years ago was the first definitive public statement of a problem that had been worrying Blue Cross executives, and a few hospital administrators and doctors, for some time. After listing and describing such abuses as overstay, overuse of diagnostic services, carelessness in ordering drugs and other treatments, and delays in reporting tests, Dr. Babcock said the blame for these and other abuses must be shared by physicians, hospitals, patients themselves, and Blue Cross. "As an administrator, it is your duty to get staff committees to investigate themselves," he told the group. "But get your own house in order also. We should, and must, make positive efforts to correct the evils our abuses present."

As president of Michigan Blue Cross, Dr. Babcock initiated an extensive study of over-utilization in Michigan hospitals conducted by a committee of the Michigan State Medical Society, which revealed that as much as 18 per cent of subscription fees and premiums paid by Blue Cross and insurance patients was going down the drain in the form of payment for unneeded services. Unfortunately, however, the society has not made public a detailed report of its findings—a circumstance that may have limited the usefulness of the study. Following a recent address to one state hospital association on the subject, for example, Dr. Babcock released the text of his remarks to members of the group who wanted to study the problem in greater detail, but had to withhold the slides giving actual findings of the study, in accordance with the policy of the state medical society. "That's the stuff they need and should have," he said regretfully. "Until we can show them the details, it's going to be difficult to get corrective measures under way."

Entirely apart from over-utilization under Blue Cross and insurance contracts, Dr. Babcock estimates that most hospitals waste thousands of dollars annually through carelessness in ordering and charging for diagnostic services, drugs and other treatments. "There is not one sitting in front of me today who didn't deliberately or carelessly throw away $20,000 in the last year," he said recently to a group of small hospital administrators. Doctors are not altogether to blame for this situation, he added. It is the administrator's responsibility to see that doctors' orders are consistent with hospital economy. "The staff must be conditioned and oriented to know what management problems are," he declared. When this is done, Dr. Babcock believes, the staff usually becomes the most loyal group in the hospital, and its best ambassadors of good will.

FAVORS INSIDE MEDICAL AUDIT

A medical staff which is technically competent, hard working and free to examine its own functions is one of the main pillars supporting a good hospital structure, Dr. Babcock has asserted. A firm believer in the medical audit, he prefers to have such professional accounting done by a committee of the staff itself, rather than an outside auditor. "An outsider is like a reform candidate in a municipal election," he explained. "The dirty linen is washed, and we go right on sinning." Organization of the audit committee at Grace

Hospital provides an instructive example of Dr. Babcock's administrative method. When such a committee was first proposed some five years ago, the staff voted the proposal down by an emphatic margin. An audit committee seemed to the staff then, as it still does to some doctors, to be a device whereby staff members would spy and pry into one another's business.

Determined to get the staff to evaluate its own performance and results, Dr. Babcock started working with the credentials committee, medical records committee, and departmental groups to tighten up professional standards generally and make staff members more precisely accountable for their records and their results. The committees soon became loaded with special projects, all of which the staff agreed were necessary and desirable. After a year or two of thus overworking its standing committees, the staff itself conceived the idea of organizing a special committee to examine staff records, evaluate performance, and conduct inquiries. The idea was enthusiastically adopted, and the audit committee was voted into existence without a single dissenting voice.

Another example of Dr. Babcock's "furnish-the-dynamite-and-light-the-fuse" method was the way he introduced G-11 soap into the hospital. "If I had ordered it myself or requested the doctors to start using it," he said, "there would almost certainly have been some resistance, and a few would have thought the new product was being jammed down their throats." Instead, Dr. Babcock asked the surgical committee of the staff to investigate G-11 — conducting tests and trials themselves and finding out what other doctors who had used the product thought about it. Within a few weeks, the committee returned a unanimous recommendation in favor of G-11. The recommendation was processed through regular staff channels.

In Dr. Babcock's view, the effectiveness of these methods does not depend on the fact that he is a doctor who grew up, so to speak, in the hospital. The programs in hospital administration should teach the importance of good staff relations to students, he believes, and he teaches his administrative residents these and other technics of becoming indispensable and liked. The hospital administration programs are doing a good job, Dr. Babcock believes. "Certainly these courses have improved the quality of hospital administration tremendously," he said not long ago.

Among other things, Dr. Babcock believes, the improved quality of administration will aid the drive for accreditation. The Joint Commission can greatly stimulate and guide the improvement of medical care in hospitals, as he sees it, but the real drive has to come from within hospitals and medical staffs themselves. In this as in other functions, Dr. Babcock is convinced, the rôle of the administrator is to "do most of the work yourself and give the committee credit."

ORDERLY MIND HELPS

In Dr. Babcock's new assignment, "the committee" includes representatives of the five national organizations that established and are conducting the accreditation program. The representatives are ultimately responsible to their respective memberships, and the memberships cover every conceivable shade of opinion on every aspect of accreditation—including some who don't want any part of it. Under these circumstances, an organization is likely to move ponderously, if at all, and yet it is Dr. Babcock's job to keep the program marching forward vigorously toward the goal of accreditation for all —a task that could easily tax the abilities even of a man who has trained for his career since the age of two. Possibly the best promise that Dr. Babcock is equal to the job is suggested in his reply to a friend who asked him something recently about the mechanics of conducting inspections of army field hospitals under combat conditions.

"It helps to have an orderly mind," Dr. Babcock said.

Medical Profession and Public Must Be Shown Value of Accreditation: Crosby

ATLANTIC CITY, N.J.—Better understanding of hospital accreditation on the part of the medical profession and the public, as well as hospitals, was named as an important objective of the Joint Commission on Accreditation of Hospitals in a talk here by the commission's outgoing director, Dr. Edwin L. Crosby.

Dr. Crosby addressed a general session of the Middle Atlantic Hospital Assembly here May 29, three days before he left the commission to become executive director of the American Hospital Association in Chicago.

As it has been at all the hospital conventions this year, the session on accreditation was among the liveliest and best attended meetings on the convention program.

There is some question whether the medical profession fully understands the nature and purpose of hospital accreditation, Dr. Crosby said in his address. To remedy this situation, he said, a series of regional meetings is planned to inform professional groups on every aspect of the accreditation program. Moreover, Dr. Crosby added, doctors and hospitals have a responsibility to work for better understanding of accreditation on the part of patients and the community.

"The greatest bulwark against socialized medicine is to convince the American public that it is getting quality medical care in today's hospitals," he declared.

While there are only a few large hospitals in the country that are not approved today, Dr. Crosby reported, many small hospitals have had trouble gaining accredited standing. These hospitals would be more successful in seeking approval if they limited their work to areas that local doctors are fully competent to handle, instead of undertaking highly specialized functions, he suggested.

In addition to smaller institutions, the nation's mental hospitals are far behind general hospitals in the achievement of accredited status, Dr. Crosby said. More than half of all hospital beds in the country are in mental hospitals, he pointed out, yet only 31 per cent of the mental hospitals are accredited. "This is a chief area where a program must be developed to bring hospitals up to standard," he concluded.

Appearing on the accreditation program with Dr. Crosby were Dr. John Hinman, assistant director of the commission, who described the hospital

(*Continued on Page* 164)

Pender Memorial Hospital, in a North Carolina county seat, has 25 beds. It serves a farming and lumbering community.

THE MODERN HOSPITAL OF THE MONTH

From the standpoints of efficiency and control of patients and visitors

"Cross" Plan Offers the Most for the Money

LESLIE N. BONEY
Architect, Wilmington, N. C.

THE 25 bed Pender Memorial Hospital is located in Burgaw, N.C., the county seat of Pender County, and was erected by the board of trustees of the hospital headed by J. Vivian Whitfield, with assistance from the North Carolina Medical Care Commission and the U.S. Public Health Service. The entire county, the principal industry of which is agriculture (90 per cent of 18,600 population), is served by this unit; there are also lumber and allied manufactured products.

The plot is ample in size to allow for future expansion and also for the erection of a future nurses' home and health center. The site is level, with an abundance of pine trees along the perimeter, and in the foreseeable future will be in the center of a quiet restricted area of the town. The building is serviced by city water and sewer service and electrical service from the area power company.

When the architect was selected, the decision was immediately made that a hospital of this size should be housed in a one story structure and that primary consideration should be given to the efficiency of nurse-patient operations. After the conventional "T" shaped layout was studied for some time it was decided that the cross shape would be more desirable for control of patients and visitors as well as hospital staff. The legs of the cross contain primarily the four basic elements: two for nursing units, one for service, and one for operating suite.

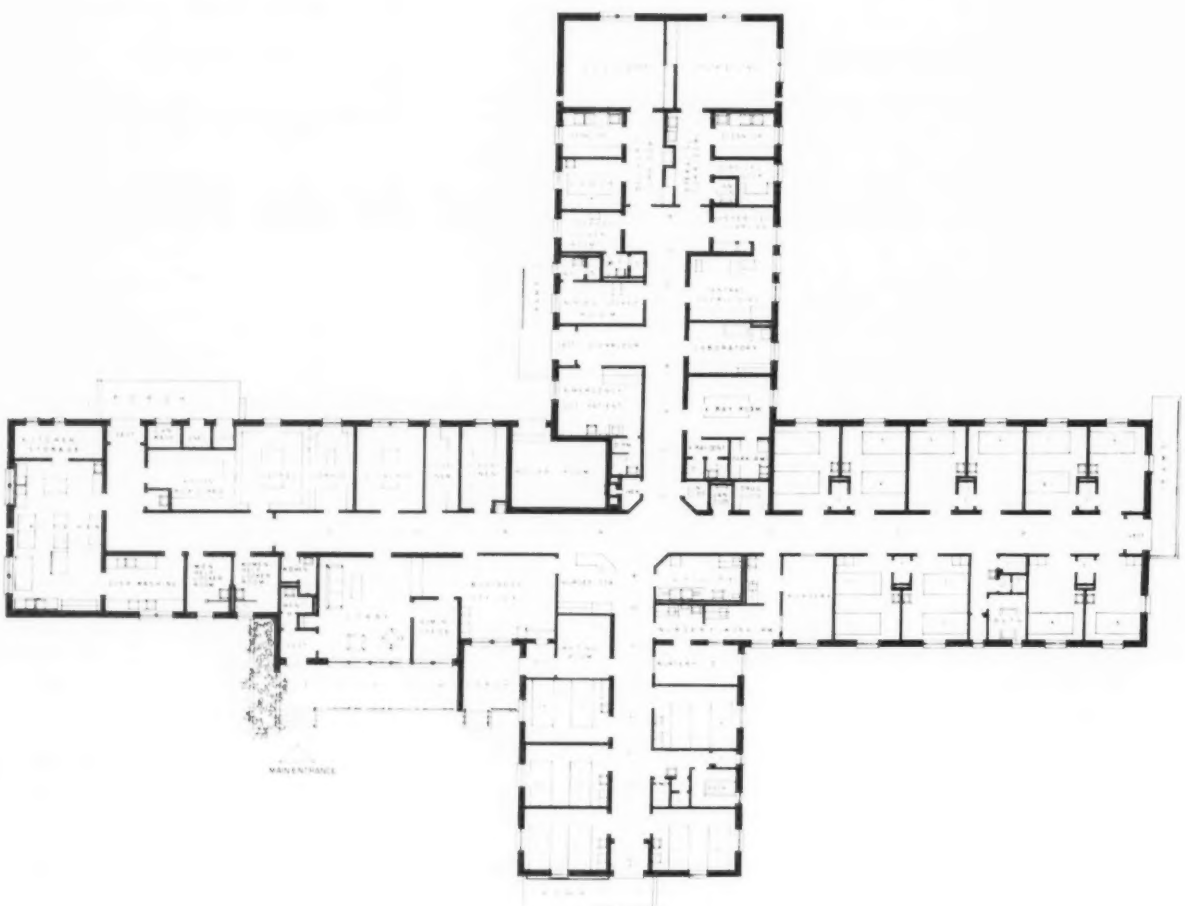
The service wing contains the public waiting rooms and business offices, both located near the axis of the cross for maximum control. Also located in this area are the kitchen, boiler room, dining facilities, and other "noise making" activities.

The operating wing houses the emergency suite and ambulance entrance, with easy access to either the operating rooms or nursing units. X-ray and laboratory and other outpatient facilities are located in this area and will serve the community as well as the hospital until the new health center can be constructed. The operating and delivery suites are separated completely but are located side by side at the end of this wing with doctors' and nurses' lockers and sterilizing activities.

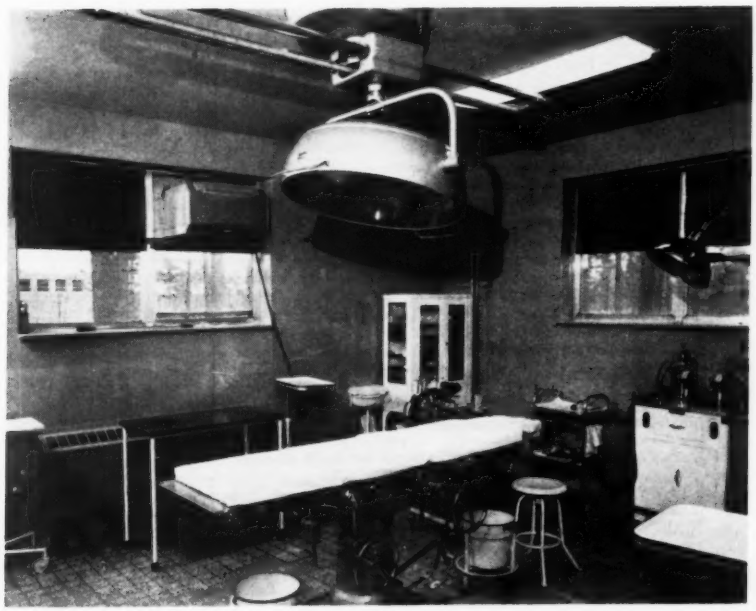
The two nursing units are in the southwest part of the building in order that maximum natural ventilation of

There is plenty of room for expansion at Pender Memorial Hospital. The site is level, with many pine trees on the spacious grounds. Now on the outskirts of Burgaw, some day it will be in the center of a quiet residential area.

The plan, in the shape of a cross, permits the hospital's four basic elements to be located in wings centering in a control area. The two nursing wings are at the southwest; the operating wing and the service wing are opposite these.



Typical semiprivate room (above) and operating room setup (below).



The hospital presented here has been selected as The Modern Hospital of the Month by a committee of editors. Award certificates have been presented to the hospital, the architects and the state officials. A similar award will be made by The Modern Hospital each month.

patients' rooms can be attained; 19 of the 25 beds receive sun during the day. All rooms are private or semiprivate, with 15 of the beds having communicating toilet facilities. Exits to quiet areas are provided at the ends of the nursing units in order that ambulatory patients and visitors may take advantage of the southern exposure and the quiet area under the pines. Ramps to the outside are also provided for wheel chair patients.

The center of the cross is the nurses' station and control point, ideally located for visual control of all four elements down the corridors, and when the personnel is reduced at night this location has a distinct advantage, as the nurse can see the reception room and act as receptionist and admitting clerk. The nursery is located across from the nurses' station and babies can be supervised from either wing of the nursing unit.

Isolation is readily accomplished by starting at the extreme end of either nursing unit and screening off with a portable partition the necessary number of rooms.

The exterior walls of the building are load bearing and consist of red brick manufactured in the area and masonry block back-up, with limestone trim. Footings are concrete reinforced as required by soil conditions. The floor and roof are constructed of steel bar joists with 2 inch concrete slab over steel lath. The flat roof is of a 20 year bonded built-up material.

Interior partitions are load bearing at the corridors and are generally plastered over masonry block or glazed structural tile. Floor surface in wet areas is ceramic tile, and conductive terrazzo is used in the operating and delivery suite, with all other areas having surface of asphalt tile. Walls of the waiting room and business offices are paneled with oak plywood at wainscot height. Structural glass from floor to ceiling was used in the operating and delivery rooms to reduce the number of germ concealing joints to a minimum. The ceilings are generally acoustical plaster throughout.

Heating for the building is provided by a two-pipe system of low-pressure steam. Wall hung convectors are used for the areas to be heated. The system is fired with oil.

COST STATISTICS

Total project cost (including groups II and III)	**$194,432.00**
Cost per bed (25 beds)	**$7,776.00**
Cost per square foot	**$14.91**
Cost per cubic foot	**$1.24**
Total square foot area	**13,034**
Square foot area per bed	**522**
Total cubic feet	**156,408**
Total construction cost	**$155,125.00**
Cost equipment (groups III & IV)	**$30,000.00**
Architect's fee	**$9,307.00**

Department heads are critical employes when it comes to operating costs and savings, so——

Don't Neglect Your Supervisors

EDMUND MOTTERSHEAD
Mottershead Associates, Chicago

A LEADING national business publication recently surveyed the thinking of 2500 supervisors and department executives. Results indicated that supervisors felt a "lack of recognition"—were hard put to figure out just where they fit in the management-labor picture. What executives actually meant when they said they were "neglected" was that the real potentialities and importance of their position was neglected by management.

Department heads are key men in hospital labor relations. They are critical employes in the field of operating costs and savings. They have responsibilities for operations and an opportunity to contribute better methods. They have a task of real leadership. And it is the responsibility of administrators and directors to take the initiative in developing various executives and supervisors to the level of ability and performance where proper "recognition" might be justified.

LOOK BEFORE YOU HIRE OR PROMOTE

Top management reports indicate that it costs upwards of $1000 to hire a man from the outside—and then lose him after it is discovered that he has no talent as a supervisor. It costs far more to raise a man from the ranks to supervisory capacity and later discover that he lacks executive and leadership qualities. And hidden in both situations are the excess waste, bad feelings and roiled tempers resulting from sundry mix-ups and confusions brought about by having the wrong man in the key supervisory or executive job. Picking the right man at the outset cuts these costs where they really count.

HOW TO TRAIN AND UPGRADE SUPERVISORS

CHECK THESE FIVE SIMPLE STEPS

	O.K.
1. SET UP YOUR TARGET: Your job is building men—not just operations.	
2. Plan WHAT to teach your men:	
A. ATTITUDES: Develop a positive, enthusiastic attitude toward his job, his hospital, the work, his fellow employes. Develop a willingness to go out of his way to cooperate. Instill ambition.	
B. KNOWLEDGE: Expect a thorough knowledge of all machines, materials, methods and jobs in his department. Train him to impart knowledge, manage his department, make decisions, and accept and carry out responsibility.	
C. SKILLS: Help him develop skills in dealing with people, skills in planning the work, in meeting difficulties, in developing methods.	
D. WORK HABITS: Guide him in developing work habits of self-discipline and self-improvement; help him organize his use of his productive time; develop habits of teamwork with the rest of the organization.	
3. Plan HOW to teach your supervisors:	
A. In "small doses"—don't cram them too much at once.	
B. With semiformal "training classes"—once a week, 1 hour or so.	
C. With informal morning discussion sessions—10 minutes a day.	
D. With personal coaching—individual conferences on problems.	
E. Work with a definite training or probation period.	
4. Set up a DEFINITE PROGRAM:	
A. Demonstrate the importance and opportunity of the job at the beginning; show him how he can make progress and see it.	
B. Plan definite training methods. Good teaching means thorough explanation, demonstration; check and question each step.	
C. Plan to give him encouragement as he shows improvement.	
D. Plan for follow-through to see if he is making the grade. Allow for additional coaching to reexplain, correct errors, and so on.	
5. Provide INCENTIVES to stimulate learning and better supervisory performance.	

Study finds supervisors are hard put to figure out where they fit into the management-labor picture

Who are the successful department heads in your hospital? What characteristics and abilities do they have that you should look for when picking a man for a supervisory job? First of all, look for men who have good health, generally good appearance, good home life. Check for honesty, personal habits of integrity. Ambition is valuable, too, as a man who can see an expanding future will work toward it. Basic intelligence, as contrasted with job knowledge, is important. Try using some practical aptitude tests for mental ability, social ability, mechanical ability. Try to find a man with a cheerful personality whom people like readily, and who has the ability to handle people under pressure.

Use a formal application blank specifically designed for your hospital needs. Use a planned interview with a check list to be sure you cover all the bases. Check references by telephone or in person; people don't give facts by mail. And sell the newly hired or newly promoted supervisor on the opportunities of his job at the beginning. Careful selection of supervisors for specific traits and abilities rather than simple job knowledge and seniority will solve numerous supervisory problems and reduce costs in this area.

HOW TO SUPERVISE YOUR SUPERVISORS

CHECK THESE BASIC POINTS

	O.K.
1. SET STANDARDS for supervisory job performance. Develop a check list or merit rating sheet to rate your supervisor's performance, either on the basis of a job analysis of all the factors of his job, or on the basis of key elements of results.	
2. EXPLAIN CAREFULLY any new policies or programs. Be sure he understands and is enthusiastic. Question and check his understanding. Maintain enough personal contact with him to be close to what he is really thinking and feeling about things in the hospital.	
3. PROVIDE INCENTIVES AND ENCOURAGEMENT. Try an occasional contest or competitive device, but be sure to equalize all the factors in the situation for fairness—like any good handicapper. Provide that necessary pat on the back for good work and conscientious efforts.	
4. GIVE HIM SUPPORT. Feed him new ideas, new methods, management thinking. Back him up with good engineering, good equipment, good sources of materials, as good workers as can be hired. Provide him with a basically sound "deal" in which to operate.	
5. TEST PERFORMANCE on results. Give him a goal or quota to shoot at and make it one he can accomplish with the men and machines at his command—or surpass with a little extra effort.	
6. TEST PERFORMANCE on costs. Keep records of waste, overtime work needed, and other key cost factors. Show him the facts so that he can spot the weak points in his performance.	
7. FOLLOW UP PERSONALLY. Go out into the department with him and help him with specific job problems. Take time to have individual personal "counseling" interviews with each supervisor periodically to check over individual problems he may have.	
8. SHOW HIM HIS PROGRESS so he can see it in terms of increased efficiency of operation.	
9. BE ALERT to his attitudes and habits while you are upgrading his job knowledge and job skills as a supervisor. The "best" supervisor you have may possess only mediocre "ability" but a terrific attitude.	
10. HE IS IMPORTANT to you—let him know that he, personally, is more important to you as a man than the operations he is responsible for. You are building MEN first. Good supervisory leadership can make results almost automatic.	
11. GIVE HIM RESPONSIBILITY—AND AUTHORITY to go with it. Any man who is willing to assume full responsibility for an operation needs full authority to handle the problems connected with it. If he prefers to depend on others, he may simply feel he hasn't the authority to do a good job and consequently can't accept responsibility.	

HOW TO TRAIN SUPERVISORS

Of department executives queried 78 per cent stated that they were given no specific training in labor relations or in handling personnel problems. Only 14 per cent of supervisors stated that they received such training. If management feels that executives fail to carry out their full responsibility in the area of labor relations, it is easy to see why many of the men fail: They simply do not know what to do, how to do it, or why they are doing it, if at all.

There is an old saw that runs: "Save your pennies, and the dollars will take care of themselves." It might well be reworded for modern hospitals: "Build your supervisors, and the efficiency of your basic operation will grow automatically."

The administrator or director who says: "Good men don't need to be trained," is like the little boy who objects to a bath by saying, "I'm clean anyway, Ma." It has been demonstrated that training, in its true sense, is necessary for all executives and supervisors on a continuing basis as long as they work for you.

Such training means more than just training in labor relations or job knowledge. It involves training in leadership abilities, in executive tasks, in making decisions, in watching and controlling costs, in developing methods, in carrying out responsibility, in communicating management thinking to the working force, and labor thinking to management.

Your primary task is to develop in supervisors a positive *attitude* toward their work, their service, their hospital, their workers. Next, instill a thorough knowledge of jobs, materials, processes and methods, knowledge of hospital policies and business conditions. Follow this with development of skills in handling people, in planning and laying out the work, in carrying out responsibilities as an executive. Finally,

plan to develop in supervisors work habits of organizing their time, of self-improvement and teamwork.

Train your men in "small doses." Don't try to cram them full of new ideas and new skills all at once. Plan either formal training meetings or early morning discussion sessions. Allow for plenty of follow-through and personal coaching by a top management man.

Start by demonstrating to the new supervisor the importance and opportunity of his job. Plan the training methods to use on each man. Plan to give him encouragement and show him his improvement. Allow for follow-through and reteaching as needed. And provide incentives to stimulate learning and effective performance as the new supervisor or department head continues to gain in skill.

HOW TO SUPERVISE SUPERVISORS

Among the most important things that can be done to create better teamwork between supervisors and top management are: better communications—more information for supervisors; more respect for and confidence placed in the supervisors; making them feel they are really a part of the hospital team; giving them sufficient authority to carry out their responsibilities; giving them recognition and being honest with them. Supervision of executives and supervisors is the highest task and greatest personnel responsibility of modern hospital management.

When queried on this subject of long-range supervision, one executive recently stated that he felt that department heads and supervisors were either cut out for their jobs or not. They either found supervision a challenging and interesting job, or flubbed it rapidly. He went on to say that he believed the supervisor's interest in his organization must be created and fostered by top management to prevent monotony and maintain his early enthusiasm.

The key to good supervision by top management, over executives and supervisors, is to set up clear standards of what constitutes good supervisory performance in the department, standards which every supervisor can easily understand, and then show him from day to day or week to week just how he is managing to meet those standards.

Keep your supervisors informed. Explain any new policies, new programs or methods of your hospital. Maintain enough close personal contact with them to keep in touch with what they are really thinking. Give them some incentive and encouragement. Recognition for good work is as important as increased earnings—usually more important.

GIVE THEM PLENTY OF SUPPORT

Give the supervisor plenty of support. Make him feel that he has strong backing from the rest of "top management" to which he belongs. Feed him new ideas, management information. Gauge his performance in specific factors which are easily measured, so that you can help him spot weak points in his own supervisory performance and correct them. Spend some time with him in individual counseling to help him with special problems and to get better acquainted with him personally.

And, let him know that you are more interested in him than you are in his immediate work record, that you are interested in increasing his executive ability and responsibility capacity. The efficiency of your hospital's basic operations will take care of itself.

HOW TO PICK GOOD SUPERVISORS

CHECK THESE EIGHT SIMPLE STEPS

O.K.

1. COUNT THE COST! It costs from $1000 to $3000 to hire (and lose) a man hired from outside for supervisory work. It costs at least as much to upgrade a man from the ranks—and many times more to pick the wrong man.
2. STUDY YOUR SUCCESSFUL SUPERVISORS: What qualities do they have and use that you should look for in selecting a supervisor or lead-man?
   - A. Good health—to do a full day's work every day.
   - B. Good appearance—clean, shaved, neat, orderly.
   - C. Good home life—a happy home makes a "happy" man.
   - D. Honesty, sobriety, personal integrity, good habits, reliability.
   - E. Ambition—sufficient "drive" to get ahead.
   - F. Intelligence—ability to learn his job and do it better.
   - G. Mechanical ability—to understand, maintain and teach equipment.
   - H. Personality—cheerful, likeable, courteous.
   - I. Ability to handle people—tact, diplomacy, firmness.
   - J. Ability to plan and organize.
   - K. Judgment and decision.
   - L. Job knowledge—control of operations and costs.
   - M. Others you find necessary: .....
3. STUDY YOUR FAILURES: What qualities did they have that you want to look for and AVOID in future supervisors?
   - A. Poor health
   - B. Domestic difficulties
   - C. Too much "education"
   - D. Doubtful honesty
   - E. Insufficient job knowledge
   - F. Can't take responsibility

   OTHERS: .....
4. USE an application blank that covers all the bases and reveals the facts.
5. PLAN your interview before placement; use an outline and follow it!
6. CHECK REFERENCES in person or at least by telephone; not by mail.
7. TRY practical aptitude tests of intelligence, mechanical ability.
8. SELL him the opportunities of the job. Develop interest at the start.

"God's Geese," Daughters of Charity of St. Vincent de Paul, enjoy a stroll along the Boardwalk at Atlantic City

Catholic Association Meets, Prays, Elects

Sisters hear talks on accreditation and business problems; purchasing institute features lively debate on group buying

ATLANTIC CITY, N.J. — The 39th annual convention of the Catholic Hospital Association here last month opened with a wisecrack and closed with a prayer. In between, the 2700 priests, Sisters and lay hospital workers attending the convention heard lectures and took part in discussions covering every aspect of hospital service and operation, with emphasis, always, on the Catholic hospital's responsibility for the spiritual as well as physical welfare of its patients.

The wisecrack came in a welcoming address to the convention's first general meeting by the Most Rev. Bartholomew J. Eustace, Bishop of Camden, N.J., in whose diocese Atlantic City is located. "That sea out there is my See," Bishop Eustace explained, gesturing toward the Atlantic Ocean. "Have a good time while you are here," he urged the group, "—if possible, picking up a little information along the way."

The peculiar requirements of what he described as our "age of nervousness" make especially heavy demands on the Catholic hospital, Bishop Eustace said. It is the everlasting obligation of the Catholic hospital to serve God by alleviating the ills of mankind, he added, and many of our ailments today stem from the tensions of the machine age. Patients with this kind of illness particularly need the kindly, considerate care that should be the hallmark of the Catholic hospital, he concluded.

Meeting concurrently with the general convention were special institutes on purchasing, pharmacy, medical records, and medical technology. The purchasing institute produced some fireworks when visiting lecturers clashed

Left to right: Rev John J. Flanagan, S.J., executive director of the association; Rt. Rev. Msgr. J. L. Gatton, first vice president; Very Rev. Msgr. Edmund J. Goebel, president; Very Rev. Msgr. R. A. Maher, president-elect.

Sister Vincente
Chicago
Sisters of Resurrection

Sister Mary Nazarita
Jacksonville, Ill.
Sisters of the Holy Cross

Sister Louise de Paul
Pittsburgh
Sisters of Charity

Sister Elizabeth of the Divine Heart, Portsmouth, Va.
Daughters of Wisdom

Sister Joseph Irene
Montclair, N.J., Sisters of Charity of St. Elizabeth

Hospital convention visitors are always intrigued by the elaborate headdress and flowing habits of hospital nuns. So that readers may distinguish some of the principal orders, Modern Hospital Photographer Sid Stoen took these pictures (above and opposite page) at the Catholic Hospital meeting.

with a representative of the Hospital Industries Association on the subject of group or cooperative purchasing for hospitals.

Pointing out that hospitals are not competitors in the business sense of the term, Dr. C. Rufus Rorem, executive director of the Hospital Council of Philadelphia, urged hospital representatives at the institute to work with other hospitals in the community in the purchasing of commodities, in an effort to achieve purchasing economy. If this and other economy measures were to result in a saving of 5 per cent on the purchase of commodities, Dr. Rorem said, the hospitals of America would save $80 million, which could be devoted to expansion of service or improvement of professional standards.

Also advocating group or cooperative buying for hospitals was Dewey Palmer of the Hospital Bureau of Standards and Supplies, Inc., of New York City, who emphasized the safety and economy of group action in the establishment of standards and specifications for various supply and equipment items used by hospitals. He cited several examples of materials that were found to be inferior in tests conducted by his bureau—tests the individual hospital could not ordinarily afford to make, he added.

Taking issue with the proponents of group purchasing, John J. Egan, vice president of S. Blickman, Inc., and the Hospital Industries Association, expressed the view that group buying was likely to be price buying, with emphasis on the business rather than the service aspect of hospital operation. A trend toward group buying would result in eventual elimination of the local dealer, Mr. Egan warned, with resulting loss of the invaluable services performed for hospitals by these dealers. Selling and service costs must be paid in any instance, he pointed out; these must be added on the manufacturer's side if the manufacturer performs the service, and on the hospital side if hospitals perform these services for themselves through cooperative agencies. Mr. Egan also warned against the adoption of any purchasing method or system which overlooked the reputation and the financial and ethical background of the supplying companies.

Replying to Mr. Egan, William H. Markey, secretary of the Council on Financial Management of the Catholic Hospital Association, said that hospitals in cooperative buying groups were not emphasizing economy at the sacrifice of service. "We're trying to save money as well as lives," he said. "They are not incompatible."

In the discussion that followed this exchange, Mr. Egan made it clear that he had not intended to charge any hospitals with neglect of duty. He was simply concerned, he said, that the desire for efficiency should not push the primary obligation of service into the background. Concluding the discussion, Albert H. Hall of the National Institute of Governmental Purchasing, Inc., of Washington, D.C., acknowledged that group buying is not a panacea, and that education of purchasing agents and improvement of purchasing procedures are the primary objectives of intergroup cooperation in purchasing.

As it has been at all the hospital conventions this year, the most popular subject among many presented during the Catholic association meeting was medical staff organization. Addressing a crowded meeting on staff by-laws, Dr. Robert S. Myers of the American College of Surgeons said that proper medical staff organization and, especially, proper and efficient discharge of responsibilities by appointed committees of the medical staff were the essence of good patient care in hospitals today. "The keystone of an accredited hospital is the medical staff," Dr. Myers said. "The program of hospital accreditation is a relatively simple thing and should not be surrounded by mystery, misunderstanding and misapprehension. It is concerned with just one thing—the welfare and safety of the hospital patient."

STAFF BY-LAWS SHOULD INCLUDE

The following points must be covered in the staff by-laws and regulations of the accredited hospital, Dr. Myers said:

1. A descriptive outline of the medical staff organization.
2. A procedure for granting and withdrawing privileges to physicians to work in the hospital.
3. A statement of the necessary qualifications that a physician must have to work in the hospital.
4. A definite statement forbidding the practice of the division of fees under any guise whatsoever.
5. Provision for regular meetings of the medical staff.
6. Provision for keeping accurate and complete clinical records.
7. A statement to the effect that the physician in charge of a patient shall be responsible for seeing that all tissue removed at operation is delivered to the hospital pathologist and that routine examination and report are made of such tissue.

Sister Rita Capistran
Toledo, Ohio
Gray Nuns of Montreal

Sister Annunciata
New York City
Franciscans of Allegany

Sister Leonarda, Nelsonville, Ohio; Sisters of St. Francis of Penance & Christian Charity

Sister Mary Joanne
Lodi, N.J.
Felician Sisters

Sister St. Regis
New York City
Misericordia Sisters

8. Provision for routine examination of all patients on admission, and recording of preoperative diagnosis prior to operation.

9. A rule permitting surgical operation only on consent of patient or his legal representative, except in emergency.

10. A statement providing that, except in emergency, consultation with a member of the consulting or the active medical staff shall be required in all major cases in which a patient is not a good risk, in which the diagnosis is obscure, and in all first cesarian sections, sterilizations or other operations that may interrupt a known, suspected or possible pregnancy.

11. A regulation insisting that all physicians' orders must be in writing and signed.

The most commonly occurring deficiency in medical staff organization today, Dr. Myers said, is failure of the medical staff to assume responsibility for disciplining its own members; when this happens the staff forfeits its right to regulate its own affairs.

In such cases, it was suggested at another meeting, the administrator and governing board of the hospital may ascertain the quality of service rendered by the staff as a whole and by individual physicians by means of a medical audit performed by a qualified, objective physician or by a committee of the hospital staff itself. Speaking at a conference on medical records, Sister Lydia, administrator of St. Vincent's Hospital of Indianapolis, described the medical auditor as a "silent partner of the administrator, governing board, and medical staff in judging, impartially and without prejudice, the work of the staff."

Sister Lydia described in detail the methods used by an individual outside auditor who had conducted medical audits at St. Vincent's with resulting improvement in staff performance.

Reporting an analysis of credit and admissions policies in hospitals, Theodore Fabisak of the Massachusetts Division of Hospital Costs and Finances at Boston pointed out that 70 per cent of hospital admissions today are patients who are Blue Cross or commercial insurance beneficiaries. "About one-half the remaining 30 per cent are good risks who will pay their bills," Mr. Fabisak stated. The remaining 15 per cent is not sufficient to alter operating capital enough to justify the policy of requiring payment in advance from all patients, he concluded from the study.

ADVANCE PAYMENT UNNECESSARY

Agreeing that mandatory advance payment is not necessary to hospital solvency, Sister Mary Thomas of Mercy Hospital, Baltimore, said a survey of 101 hospitals revealed little difference in accounts receivable standing and experience between hospitals requiring advance payment and those with a more liberal credit policy. However, Sister Mary Thomas added, each hospital must make its own decision, dependent on the particular public it serves and its place in the community. "We can win friends and remain solvent by being efficient," she concluded, "but more especially by being Christlike and emphasizing the spirit of mercy in our dealing with patients."

"The success of a supervisor is 50 per cent dependent on his ability to understand and work with people, whereas the success of an executive is 80 per cent dependent on these human relations abilities and only 20 per cent on technical knowledge and skills," Dr. Walter J. Coville, clinical psychologist on the staff of St. Vincent's Hospital, New York City, told the convention in a session on human relations. The good leader is a good leader because of certain innate characteristics and not because of authority vested by title, Dr. Coville stated. Thus persons selected for positions of leadership in the hospital must be emotionally secure, he said; secure persons do not need defenses that are detrimental in their relationships with others, he explained. "The good leader recognizes the need for respect and dignity felt by every human being," he said, "and is capable of rising above her own feeling and resisting the impulse to impose her standards on others."

In hospitals as in other human relationships, most unpleasantness is based on failure of the persons involved to understand one another, and failure to understand the motivations of other individuals in relation to their jobs, Dr. Coville said. He recommended establishing group discussion programs to talk over problems and misunderstandings in hospitals. When groups representing the widely divergent fields within the hospital are brought together for such discussions, he said, each will develop a greater understanding of the work of the departments and the personalities involved.

TWO ROLE PLAYING SESSIONS

Illustrating several of the points brought out in his lecture, Dr. Coville led two "rôle playing" sessions, with members of the St. Vincent's organization taking the part of hospital workers and executives. Following the rôle playing demonstrations, members of an audience of several hundred took an active part in discussing the problems and solutions that had been presented.

At the association's annual meeting, Sister Mary Catherine Gerard of Hali-

(*Continued on Page* 144)

PROTOTYPE STUDY: 400 BED HOSPITAL

All the facts about the 400 bed hospital as it exists today—comprising a useful tool for self-evaluation and an adaptive guide to administrative planning

LOUIS BLOCK, Dr. P.H.
Program Coordinator
Division of Medical and Hospital Resources, Public Health Service

THE following prototype applies to the 400 bed general hospital.*

BED DISTRIBUTION

Major. In more than half of these hospitals, medical, surgical, obstetrical and pediatric patients have beds specifically set aside for their use. For this reason they are considered as major services in such a hospital type and size group. Medical and surgical services combined account for approximately 73.5 per cent of all beds, obstetrics for 14.5 per cent, and pediatrics for 12 per cent. This means that the average 400 bed general hospital has 294 medical and surgical beds, 58 obstetrical beds, and 48 pediatric beds. The foregoing bed distribution will be affected by assignments to additional services discussed hereafter.

Additional. In addition to the four basic groupings of patients in more than half of these hospitals, the 400 bed general hospital may make specific bed assignments for other patient groups. Because they occur in less than half of these hospitals they are considered as additional services. Table 1 indicates these additional services, frequency of occurrence, and average number of beds assigned them.

Bassinet Distribution. The average number of bassinets for newborn is almost the same as for obstetrical beds, 59.

Almost 99 out of every 100 of these hospitals have infant incubators. They average 9 to 10 such units per hospital.

More than 4 in 5 have special nurseries for premature infants.

Closed Beds. One in 5 hospitals reported beds closed for all reasons. They average 40 beds per hospital.

One hospital in 8 had beds closed for lack of personnel. They averaged 35 beds per hospital.

One hospital in 10 had beds closed for reasons other than personnel. They averaged 45 beds per hospital.

UTILIZATION

The kind, type and number of patients admitted to the 400 bed general hospital are as follows:

Admissions. An average of 12,500 patients is admitted during the year, averaging 31 admissions per bed per year.

Births. There are approximately 2375 live births during the year. Of this number 125 to 130 will be premature. There will be an average of 22 sets of twins during the year, and 1 to 2 sets of triplets each year. There will be 25 stillbirths during the year.

Deaths. There are approximately 410 deaths during the year, 290 to 295 of which are institutional (deaths occurring 48 hours or more after admission), and 115 to 120 are noninstitutional (deaths occurring within 48 hours after admission).

The gross death rate (total deaths divided by discharges) is around 3.3 per cent. This means that about 3 out of every 100 patients discharged die in the hospital.

The net death rate (institutional deaths divided by total discharges) is around 2.3 per cent. This means that 2 of the 3 deaths per 100 patients discharged are considered as institutional deaths.

There were approximately 18 to 20 premature fatalities during the year.

Autopsies. An average of 195 to 200 autopsies is performed during the year.

This shows an autopsy rate of 48 per cent (autopsies divided by deaths).

Patient Days of Care. The hospital provides around 115,000 to 120,000 days of care during the year.

Newborn Infant Days of Care. In addition, approximately 14,000 to 15,000 days of care are provided for newborn infants during the year.

Average Daily Census. An average of 320 patients is cared for daily.

An average of 39 newborn infants is cared for daily.

Percentage of Occupancy. The average annual percentage of occupancy approximates 79, varying from 70 per cent in private accommodations, 85 per cent in semiprivate, and 75 per cent in ward accommodations.

Newborn occupancy approximates 66 per cent.

Average Length of Patient Stay. The length of patient stay is 9.4 days on the average.

Table 1—Frequency of Additional Services

Patient Group	*Frequency of Occurrence*	*Average Number of Beds Assigned*
Isolation or contagious	1 in 4 hospitals	16
Newborn and mental	1 in 4½ hospitals	45
Tuberculosis	1 in 9 hospitals	29

*This is the fifth in a series of prototype developments. The first four articles of the series, "The 50 Bed Hospital," "The 100 Bed Hospital," "The 25 Bed Hospital," and "Summaries, 25 to 200 Bed Hospitals," appeared in the June 1953, the October 1953, February 1954, and June 1954 issues of The Modern Hospital. The reasons for the development of this series were explained in some detail in the first article.

This varies by type of accommodation as follows:

Private	9-10 days
Semiprivate	8- 9 days
Ward	12 days

Length of stay for all patients varies by diagnosis as follows:

Medical	15-16 days
Orthopedics	14-15 days
Genito-urinary	12-13 days
Surgical	10 days
Opthalmology	9-10 days
Pediatrics	8- 9 days
Gynecology	7- 8 days
Obstetrics	6 days
E. N. T.	2 days
All other medical services	7- 8 days

PERSONNEL

Numbers. The average number of paid personnel was 610 excluding interns, residents and students.

This amounts to an average of 180 full-time employes per 100 patients; 1.5 employes per bed, and 1.8 per occupied bed.

Job Vacancies. Nine in every 10 hospitals reported job vacancies in the graduate nurse position. They averaged 23 such vacancies per hospital.

About 7 in 10 hospitals reported vacancies in positions other than graduate nurses. They averaged 21 such vacancies per hospital.

Governing Board. The average size of the governing board is found to be 20 members.

Volunteers. Three hospitals in 5 have volunteers other than women's auxiliaries. They average 62 such workers per hospital.

Women's Auxiliaries. More than 4 hospitals in 5 have a women's auxiliary. The average membership is 530, and they have 85 members working in the hospital.

Administrator. The chief administrative officer is a physician in 1 hospital in 5, a graduate nurse in 1 hospital in 3. In more than half of the 400 bed general hospitals he is neither a physician nor a nurse, but has some other occupational background.

In more than 1 hospital in 5 the administrator is a graduate of a college course in hospital administration.

In more than half (almost 3 in 5) of the hospitals the chief administrative officer is a male.

Other Categories. One hospital in 4 employed a graduate occupational therapist; 1 hospital in 12 employed a nongraduate occupational therapist.

More than 1 hospital in 2 employed a graduate medical social service worker; almost 1 hospital in 3 employed a nongraduate medical social service worker.

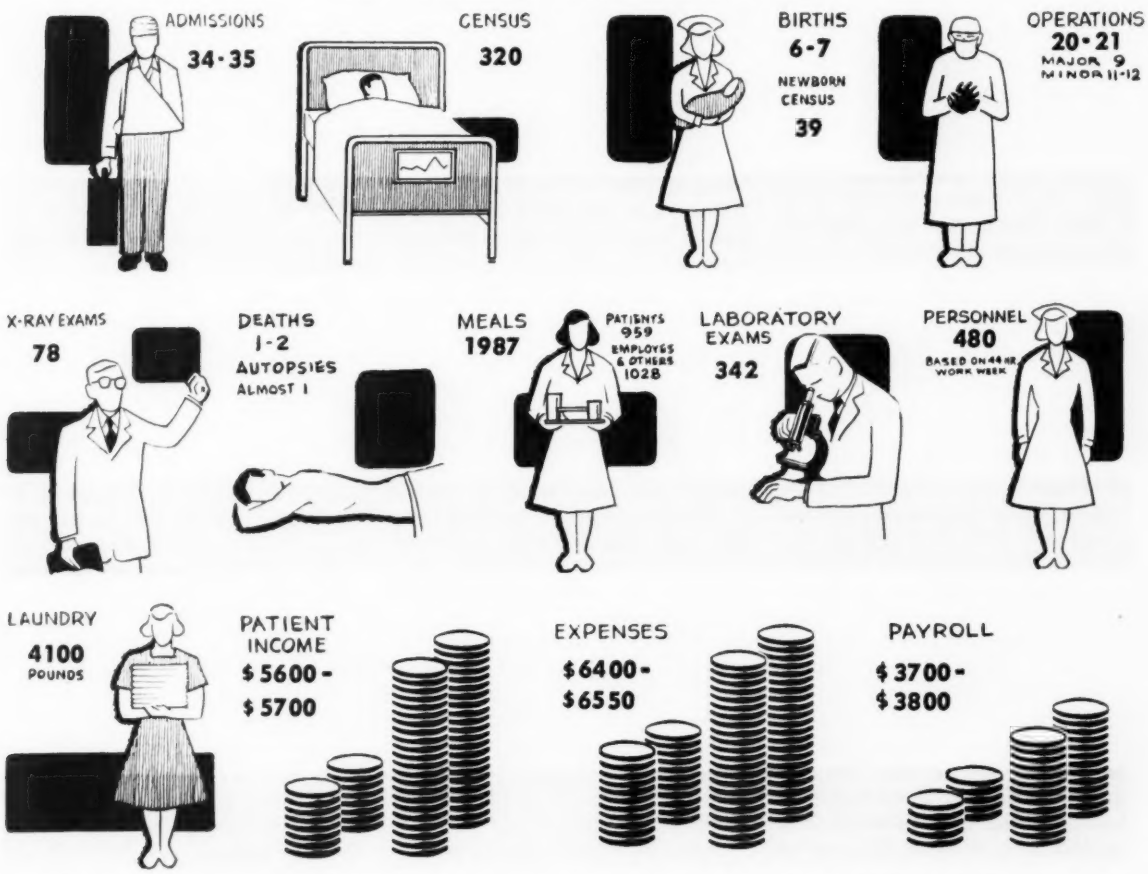
Almost 9 hospitals in 10 employed a graduate medical record librarian; 2 hospitals in 3 employed nongraduate medical record librarians.

Practically all hospitals employed a qualified dietitian.

SERVICES

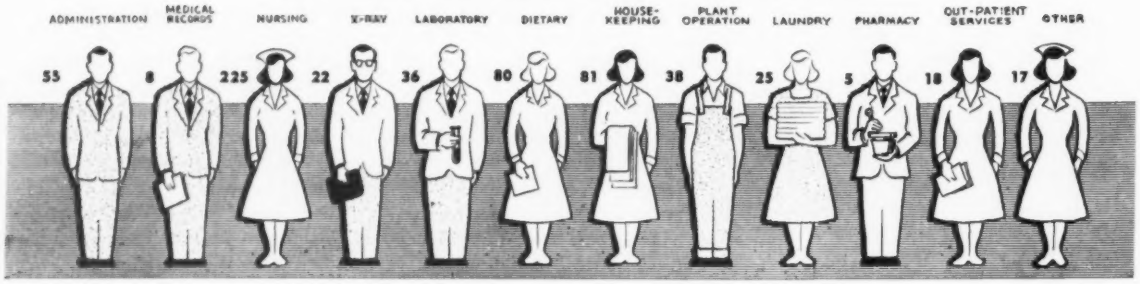
Major. The following services are found in more than half of the existing

AN AVERAGE DAY'S ACTIVITIES



In this prototype of hospital operation for the 400 bed nonprofit, general hospital, national data were used whenever available. Regional, state or special group information was adjusted to the national basis. This represents the composite or average of existing statistical data. As new or more refined information becomes available, the content may need revision. It does not generally reflect affiliated services with other hospitals and sources; nor does it necessarily indicate the ideal institution.

AVERAGE NUMBER OF PAID PERSONNEL



400 bed general hospitals covered in this prototype study.

X-ray diagnosis	100 per cent
X-ray therapy	92 per cent
Women's auxiliary	75 per cent
Patients' library service	73 per cent
Medical records department	99 per cent
Metabolism apparatus	97 per cent
Pharmacy	100 per cent
Physical therapy department	95 per cent
Outpatient department	86 per cent
Social service department	75 per cent
Clinical laboratory	100 per cent
Electrocardiograph	98 per cent
Medical library	100 per cent
Central supply	98 per cent
Blood bank	93 per cent
Cancer clinic	66 per cent
Dental department	62 per cent

Additional. Services that might be provided but are generally found to occur in fewer than 50 per cent of the facilities are considered as additional. The following indicates some of these services and the frequency with which they are provided.

Routine chest x-ray on admission	41 per cent
Postoperative recovery room	35 per cent
Children's educational program	27 per cent
Occupational therapy department	36 per cent
Electroencephalograph	48 per cent
Mental hygiene clinic	32 per cent

DEPARTMENTS

Medical Staff. The average 400 bed general hospital has 278 staff appointments. Of this number 124 are active, 28 associate, 96 courtesy, 12 consultants, 6 honorary and 12 other types of appointments.

Almost all of these hospitals, *i.e.* 98 in 100, have a chief of staff. Almost all, 98 per cent, have a written set of regulations. All have a regularly scheduled meeting of the staff. All have standing committees of the staff. Less than 1 hospital in 5 allows nonstaff members to practice in the hospital.

More than 9 in 10 hospitals, 97 in 100, have restrictions on staff physicians' surgical privileges. Almost 1 hospital in 2 provides examining rooms primarily for ambulatory patients of the medical staff.

One hospital in 4 reports physicians' offices in the hospital or on the grounds for seeing private ambulatory patients.

Operating and Delivery Rooms. The 400 bed general hospital averages 10 operating rooms, 6 major and 4 minor.

The average number of operations approximate 7300 per year. Of this number about 3200 are major and 4100 are minor.

The hospital averages 3 to 4 delivery rooms and 6 to 8 labor beds. There are about 2400 deliveries per year.

Recovery Room. Almost half of the hospitals have a postoperative recovery room. They average 12 recovery beds.

X-Ray. Approximately 28,000 to 29,000 x-ray examinations are given during the year.

Ninety-nine per cent of the hospitals have physician staff members specializing in radiology; 89 per cent, full time, and 10 per cent, part time.

Almost all of the hospitals have x-ray facilities available to private ambulatory patients of physicians.

Laboratory. Approximately 125,000 clinical laboratory examinations are performed annually.

Ninety-nine per cent of the hospitals have physician staff members specializing in pathology, 96 per cent have them full time and 3 per cent have them part time.

Practically all of the hospitals have all tissue removed in surgery routinely examined by a pathologist.

Practically all hospitals have laboratory facilities available to private ambulatory patients of physicians.

Dietary. An average of 725,000 meals is served annually; 350,000 are served to patients and 375,000 to employes and other persons.

Almost all (98 per cent) of the hospitals employ a qualified dietitian. They average 5 per hospital.

More than 9 hospitals in 10 use gas for cooking.

Less than 3 hospitals in 5 have mechanical centralized dishwashing service; 2 in 5 have mechanical and decentralized dishwashing service, and the remainder have manual and decentralized service.

About one-half of the hospitals have a centralized food service.

About 4 hospitals in 5 have selective menus. Two in 5 have them for all patients and one in 2 has them for private patients only.

Laundry. Almost all (98 per cent) of the hospitals operate their own laundry. Those that do average 16 to 17 hospital beds per laundry employe and require 25 employes per hospital. In these hospitals the laundry processes approximately 3,000,000 pieces, or 1,500,000 pounds per year.

FINANCIAL

Assets. Total assets per bed amount to about $14,000.

Plant assets per bed approximate $8000 to $9000 a bed, or about three-fifths of total assets.

Expense. Expenses approximate $2,200,000 per year.

Average expense per patient day amounted to $20, varying from $20 for private patients, $18 for semiprivate and $21 to $22 for ward patients.

Average expense per patient stay amounted to $185 to $190.

Pay Roll. Average annual pay roll amounted to $1,320,000.

Average annual salary per employe amounted to $2300 to $2400.

Average pay roll amounted to $11.60 per patient day.

Income. Patient income for the year approximated $2,030,000. Patient income per patient day averaged $17.50, varying from $32 for private patients, $19 for semiprivate and $11 to $12 for ward patients.

Average patient income per patient stay amounted to $165 to $170.

Patient income amounted to 88 per cent of expenses.

This hospital has space on all sides for expansion. A new nurses home is to be erected at right angles to the wing extending at the left. The hospital owns a productive farm.

Ohio Valley has found a simple but effective formula for establishing good public relations:

Make Friends by Telling the Facts

ERNEST P. RIBET

Public Relations Chairman
Ohio Valley General Hospital, McKees Rocks, Pa.

STARTING a public relations program is like buying a train ticket. The first decision to make is where you want to go.

Our program at Ohio Valley General Hospital, McKees Rocks, Pa., launched five years ago, had a number of destinations. We considered our basic needs, and set out to fill them. In brief, here are the essential considerations that have guided us in our work:

1. We need patients. We feel they will come to us, gladly and in a frame of mind to get well, if they know, like and respect us.

2. We need doctors. We think their morale, loyalty and performance can be stimulated by recognition.

3. We need nurses and students. We believe both the student and graduate are attracted to the hospital that cultivates community prestige.

4. We need volunteers. We are blessed with a corps of energetic ladies who lavish their spare hours on us, raising money, serving patients, manning the switchboard, and helping in countless ways. We feel the least they deserve is an occasional public expression of gratitude.

5. We need employes. We value their loyalty and interest in our purpose. We try to keep them well informed so they, in turn, may transmit the facts to their friends and others. We attempt to applaud their accomplishments at every opportunity.

6. We need our Sisters of the Holy Family of Nazareth. Since ours is a nonsectarian hospital, their garb may puzzle some who come through our doors. But their kind ways and earnest efforts have won the love and respect of many friends, to whom we give regular reports on their welfare.

7. We need benefactors. Without their philanthropy, our hospital would not exist. Ordinary etiquette requires not only that we thank them but also that we tell them often of how their gifts are aiding the sick and newborn.

8. We need directors. They are the top echelon but, lo, they are flesh and blood and their hearts beat the same as that of the weary lady in the laundry. We feel it would be rude to take their services for granted, and we seek to let them know we are grateful for guidance and long hours of service.

Jackie Durkin, first baby born in the "new" hospital, is now 5 years old. He has lent his happy smile and healthy features as "cover boy" to the anniversary issues of the hospital's magazine each year since.

Almost any general hospital can accept this same broad base as the foundation of its public relations program. The trick, of course, is to build from there.

One of the facts of life that an administrator has to look straight in the eye is that his hospital is being talked about: in the home that welcomes a new baby, in the police station that handles emergencies, in the high school where girls discuss a nursing career, in the legislative caucus that considers appropriations, in cafes, street cars and country clubs. The anecdotes that spring from a person's hospital experience are endless and colored with every repetition.

So constant a subject of conversation invites error and exaggeration. The public looks at unadorned truth with a weary eye. But gossip and rumor find a ready ear. And the best defense against a malicious lie or sinister half-truth is a constant, dynamic flow of factual information from the hospital that builds its character and reputation with each passing year to immunity against petty attacks or slander.

So many chapters in the history of medicine and surgery dramatize the need of aggressive communications that the anemic consideration of its values by many modern hospitals defies understanding.

Poor Semmelweiss sat in his study in Budapest, waiting to hear the world acclaim his defeat of puerperal fever. But few noted his message because it lacked the dramatic force to command attention.

Although Dr. Crawford W. Long of Georgia performed the first operation on a patient anesthetized by ether in 1842, many were denied the blessings of painless surgery because, as "Encyclopedia Americana" reports, "the facts did not become generally known."

The path of medicine is marked with such milestones of scientific success and communications failure. Old hands in the advertising business can cite scores of cases in which a soap company or an automobile manufacturer decided that his product had attained such perfection that no further advertising was required. Next chapter: bankruptcy.

Advertising plays no part in the operation of a general hospital, but the professional equivalent is public relations.

Through our program at Ohio Valley, we try with all our heart to hold proved friends close to us and to win new friends. The true facts of our accomplishments are so pleasant, so progressive, so human that the mere revelation of them is the simple essence of our plan.

Prayers of thanks are whispered every day in our rooms, wards and corridors. We attempt to amplify them and channel them into a "party line" that allows everyone connected with the hospital to listen in.

It was just five years ago that Ohio Valley General Hospital moved from a weary, half-century old building, buried in the depths of an industrial district, to a spanking new structure on a green, windswept hill four miles away.

The transformation was a miracle of modern America that called for interpretation and communication, even to the people who had accomplished it.

The board of directors realized that the blunt facts called for a skilled and sensitive report to the community on how the miracle had occurred. To do the job, a professional public relations counselor was retained.

Excitement and showmanship marked the opening day, which was staged as a jubilant community cele-

Josephine Roseta, director of the school of nursing, with science instructor (left), and arts teacher (right).

Student chorus singing carols. Christmas is a festive season here, with gifts and parties for everyone.

bration. A bevy of handsome ladies presided as a ribbon across the main entrance was cut. A crowd of more than 5000 cheered, and a band struck a triumphant chord. Orators at a microphone heaped praise on every donor who had contributed to the creation of the new structure. An open house allowed everyone to see the sparkling new hospital he had helped to build.

Then came the patients by ambulance from the old hospital while the news cameras clicked.

On every anniversary date since then the same message has been unfurled: the vision, sacrifice and determination of the people built the hospital, and the same proud qualities will make it grow.

With only 110 beds and 35 bassinets, Ohio Valley is small enough to permit some form of recognition for almost everyone associated with it.

Five newspapers in the area print the names of discharged patients every week. Before mailing the list, we scrutinize it carefully to avoid embarrassment or offense to anyone.

Such news is of interest to the readers of a weekly newspaper. Editors are glad to get it. And the patients themselves, particularly new mothers, appreciate a service that informs friends and acquaintances of their hospitalization.

The patient list release permits the establishment of a consistent working relationship with a type of publication that traditionally has a steady turnover in personnel. The weekly mailing bridges the gap between the old editor and the new and allows a continuity of contact and confidence that has proved to be good insurance against the printing of error or rumor. Further, it keeps the name of the hospital constantly before the reading public in a sound constructive fashion.

In addition to the happy understanding we enjoy with the community newspapers, we probably have had more news of our hospital reported in the metropolitan Pittsburgh dailies than almost any other hospital in the district, even those with five or six times our capacity.

The reasons for this are simple. Our public relations director is well known to the city editors, who trust his accuracy and accept his copy. Releases are timed right, professionally prepared, and submitted always on the basis of their news value, rather than under the traditional "worthy cause" cloak.

Stories about the hospital are evaluated and directed to the proper department of the city papers: social items to the society editor, straight news to the city desk, medical facts to the medical editor, and so on down the line.

Scrupulously avoided are unreasonable requests for photographic coverage of routine events with which hospital officials so often plague city editors. Such affairs are covered by our own commercial photographer, and the pictures are delivered with captions to the papers most likely to be interested.

The student nurse from Jonestown is featured in the release to the Jonestown paper, while the student from Smithtown is featured in the release to the Smithtown editor.

At this point, it should be apparent that the details in a program of this kind demand more attention than possibly can be provided by a stenographer, a social worker, or an administrator in his spare time.

The progressive hospital board accepts public relations as a serious responsibility which requires the best professional direction that can be afforded. Unskilled efforts in the field can lead to grave difficulties. Almost any administrator in the profession can cite instances of harm done by printed misinformation, or accurate information printed at the wrong time, by vague reports on the radio, or even by a letter which was factual but subject to misinterpretation.

It is a sad but incontrovertible fact that a hospital which has served a community for half a century with loyalty, integrity and charity can suffer grievous damage at the hands of one malicious gossip if the institution has failed to inform the public of its good deeds in a systematic fashion.

Shakespeare said: "The evil men do lives after them; the good is oft interred with their bones."

Human nature has not changed since the poet's time. And it is foolish and dangerous for a hospital to presume that a lifetime of service to the community ensures understanding and support in a situation where both are needed.

We have two publications at our hospital. A stencil duplicated newsletter titled *Hilltop News* is mailed each month to our benefactors, directors, doctors, nurses, students, alumnae, volunteers, public servants, newspaper contacts and other friends.

Hilltop News offers a courteous opportunity to say "thank you" to the garden club that brings roses to our patients, to the policemen who call at

Small patient plans to be a nurse when she grows up. Here she confides her ambition to a willing listener.

Ohio Valley nurses usually visit hospital on their wedding day. Mother Mary Margaret presents a gift.

our emergency room, to the industrialist, the debutante in the gift shop, the congressman, the aging doctor, the many good people who contribute time, effort or money to help us in our progress.

A few months ago we polled our mailing list with a letter and a return postcard, asking if our readers wished to continue to receive *Hilltop News*. Although the postcard asked for only a yes-or-no indication, so many little messages of enthusiasm were written into the margins that we left the mailing list intact.

We feared to tamper with the delicate ties of emotionalism and sentiment that the monthly letter evidently had established, with its homey prose and quaint sketches, executed by one of the Sisters. So we ignored the silence of those "subscribers" who failed to reply, and we continued to buy stamps to send them our newsletter every month.

A more formal publication of the hospital is *Panorama*, exquisitely titled, in view of the setting of Ohio Valley, which commands a melodramatic view of the spectacular industrial-rural countryside around us. *Panorama* is a printed 24 page magazine.

Traditionally, it records on each anniversary of the opening of our new building a current photograph of 5 year old Jackie Durkin, the first baby born in the present building. Handsome Jackie typifies our goal of personalizing the hospital. In a recent letter, the editor of a hospital association magazine unconsciously endorsed our aim when he wrote:

"May I tell you how much I enjoy *Panorama* despite the fact that I know not a single person in your town or community."

Issued during our June anniversary and at Christmas time, *Panorama* skips the statistics and the pie charts. Its stories are human, humorous and edifying. Its pictures are of smiling babies, pretty nurses and other attractive people. Our editor friend need not know such citizens to enjoy them. Everybody does.

We are proud at Ohio Valley of how our technic of articulation has made our hospital known and admired in many distant parts of the country. Sisters, doctors and nurses return from professional assemblies in other cities with happy reports on the kinship that our publications have established with strangers far away.

In our own community, we consider the prestige, the professional standing, and the affection we have won as precious, immeasurable assets.

We were, of course, provided with a rare opportunity to launch a public relations program, with the opening of our "new" building five years ago. And, needless to say, elegant publications and pieces in the paper would be foolish invitations to ridicule if they were not emanating from a well staffed, well administered, well equipped hospital.

Such a hospital we are fortunate to have, however, and our public relations program attempts to let no one within our service area forget that important fact.

We want our community to feel a pride of possession in its hospital. We want everyone in our hospital family to be happy to announce his association with Ohio Valley. And we aspire to be known over as wide a geographic area as possible so that our representatives will find a glad welcome awaiting them when they identify themselves with our hospital.

Who wants to be connected with an organization that nobody ever heard tell of?

Ohio Valley General Hospital represents today an investment of more than $1,750,000 from corporation treasuries and the purses of citizens in the area it serves.

The money was raised in seven challenging and exhausting fund campaigns that all but spent the energies and resources of the community leadership over a period of 10 years.

Soon to be erected is a new school of nursing, for which $550,000 was contributed in the most recent public appeal.

The hospital stands high on a hilltop, 1145 feet above sea level. It has brought health protection and a dynamic sense of accomplishment to all who have joined the battle for its progress.

This splendid, heartening climb demands that every step up the ladder be reported in all possible detail to everyone who has been even remotely connected with it.

Certainly, there are enough headlines that tell of the evil rampant in the world. At Ohio Valley, we try to make a headline, if only a small one, in *Hilltop News* of every good, kind and charitable occurrence in our little hospital universe.

Such headlines have won us the hearts of hundreds of devoted friends, in whose hands we confidently place our destiny.

Portraying Florence Nightingale, a proud student leads the procession at most recent capping ceremony.

Maintenance Engineer Stanley Klemanski has, after 24 years, outgrown his "temporary employe" status.

Methods Engineering Is Organized Common Sense

A MODERN HOSPITAL ROUND TABLE

THE methods engineering studies that have been conducted in Cleveland have aroused a great deal of interest among hospital administrators everywhere. Results of some of these studies have already appeared in The MODERN HOSPITAL, which now presents a round table discussion of the problems involved in inaugurating a methods engineering program and the benefits to be derived from it. Participants, most of whom have taken an active part in the Cleveland project, include the following: Dr. Fred G. Carter, vice president and trustee, St. Luke's Hospital, Cleveland; Guy J. Clark, who retired last month as executive secretary of the Cleveland Hospital Council; Kenneth Shoos, administrator, St. Luke's Hospital; Earl J. Frederick, methods engineer, and Dr. Frank Sutton, administrator, Miami Valley Hospital, Dayton, Ohio. Everett W. Jones moderated the session.—ED.

MR. JONES: I've been wanting for some time to discuss the interesting methods engineering work that is being done here in Cleveland. Have you encountered any objections on the part of hospital administrators to this project?

MR. CLARK: As a rule, the hospital people in Cleveland are pretty well sold on methods engineering. That was demonstrated by the fact that most of them made a contribution to our program, which lasted for a year and was conducted largely by a lay committee whose members are interested in that type of work in industry.

MR. JONES: Did you run into any road blocks or mental, if not vocal, objections to the term "methods engineering" in the hospital?

MR. SHOOS: There is a natural resistance to having someone come in and analyze what you're doing and tell you whether you're doing it right or wrong. I'm sure the personality element enters into it.

MR. CLARK: I've experienced considerable resistance on the part of some hospital people to the word "engineering." They think that it's a high-falutin' term, which they don't understand, and therefore they don't know what we're attempting to do.

A HAPPY PHRASE

MR. FREDERICK: Methods engineering, I believe, is just an organized approach of good common sense to the problems facing the hospital field today.

MR. JONES: I like that phrase, "organized common sense."

MR. CLARK: We need some of it in the hospital field, no doubt about that.

MR. JONES: If people could think of it as organized common sense, rather than methods engineering, it might eliminate some of the mental road blocks.

MR. FREDERICK: That's the way we like to look at it. We have available a few tools which we can use to analyze some of our problems, and there has been a small amount of resistance to this approach.

MR. CLARK: Isn't part of that due to the fact that each hospital considers itself unique, and thinks its problems are different?

TOP MANAGEMENT MUST APPROVE

MR. FREDERICK: That seems to be the case. Methods engineering is a new concept in the hospital field, and to be effective it has to be sold from the top down. The person responsible for the operation of the hospital has to believe in this concept and back it, in order for it to be effective in his institution.

MR. SHOOS: Some people in this top management group aren't completely sold because they don't understand it; they just reject the whole thing without knowing why.

MR. JONES: I take it that the work you've done here in Cleveland has prospered because of a good climate on the top management side. Both Dr. Carter and his successor, Mr. Shoos here, believe in methods engineering and therefore helped you with it?

MR. FREDERICK: Yes. By proper indoctrination of department heads through the hospital administrator and other executives in the hospital, a climate can be produced which will make this type of work easier.

MR. SHOOS: I have jotted down 10 items which illustrate our whole procedure. I headed it "Plan of Operation."

1. The problem or situation is presented. 2. It's brought to the attention of the administration if it's serious enough, and most of these problems are, at least in the minds of department heads. 3. Then the methods department is called in. 4. The methods department consults with the department involved in the particular problem.

MR. JONES: Instead of the methods department being superimposed on a department head, the department head really is coming in and asking for help. Is that right?

MR. SHOOS: Yes, we're giving him a way to help himself, and also we're going to support him in his efforts.

MR. JONES: That's a sensible approach.

MR. CLARK: The public is wondering why hospital costs are so high today. One of these days we're going to have to have it in black and white so we can show that our costs are justified, and by engineering methods I think we can do so.

MR. SHOOS: In the first article we ever wrote for The MODERN HOSPITAL in connection with our program

Reading clockwise around table are: Guy Clark, Earl Frederick, Kenneth Shoos, E. W. Jones, Dr. Frank Sutton, and Dr. Fred G. Carter.

here, there's a statement which I still think is pretty important. It says: "In making a comparison of the progress of hospitals and industry in carrying out daily routines which keep any organization going, it is important to remember that hospitals are not totally ineffective and inefficient." In other words, they do some things pretty well. They've made a lot of progress, and what we're proposing now is to help that progress along.

MR. JONES: What were the rest of those points mentioned earlier?

CONFERENCE STAGE IS REACHED

MR. SHOOS: We had reached Point 4, where the methods department was called into consultation. Step 5 follows that. An analysis is made. That's the mechanical part of the program where we gather the facts. After we have made an analysis and gathered the facts, we come to Point 6—the recommendations on the part of the methods department. Now what are we going to do with these recommendations? Here we have a problem, a department head admits there is a problem, and the administration says, "Well let's solve it." So Point 7 is one of the really important ones. That's when we have a conference. We get top administration, the methods department, and the department heads or other supervisory personnel concerned together, and we sit down to talk it over.

MR. JONES: Anyone who is in on the problem, concerned with it, or responsible for it sits in on the meeting?

MR. SHOOS: That's right. They all get together. After we reach the conference stage we attempt to get an agreement on what's to be done. This is the eighth point. There's some compromising and so on which has to take place, obviously, but we get some sort of agreement. It can be done at the conference level without any difficulty; at least that's my experience. Step 9 is to put the plan into effect. Then it becomes an administrative routine. Finally, Point 10 is follow-up by the methods department. It has to follow up because no one ever figures everything out completely and correctly in advance. Then it has to be agreed upon.

MR. CLARK: I don't know that I go along with the agreement idea. You have to have an exchange of ideas and a comparison with others.

MR. SHOOS: All I'm trying to outline here though is simply what we do, how we operate.

MR. JONES: Would you give us a couple of brief statements on how you follow through and why you do it?

MR. FREDERICK: Well, in setting up the recommendations, in the case of a repetitive job we outline the detailed operation of the job. Along with that goes some training of the employe, which is essential, to see that the employe learns the job so that he can carry it out.

NEW METHOD TRAINING NEXT

MR. JONES: Whose responsibility is it to train the employe in the new method?

MR. FREDERICK: It's a dual responsibility. It's the responsibility of the methods engineer who plans the new method, and also of the supervisor who must see that the new method is carried out.

MR. SHOOS: That's an important point. The methods department can't run the hospital. You still have department heads and supervisory people, who have the prime responsibility.

MR. CLARK: Yes, but if your administrator isn't in favor of all those things you aren't going to get cooperation.

MR. FREDERICK: Well that goes back to the initial statement that top management must be sold.

MR. JONES: We must not forget that. The hospital must be sold from the top down before a methods program can be effective.

MR. SHOOS: It's easy for department heads to lean on the methods department and to stop progressing. They'll argue that they're busy and don't have time to be making a self-analysis every week, and so on. I agree with them. Still that isn't any excuse for not trying to do something about their problem.

MR. CLARK: We must have more trained people. We must begin to work with other people in the community, to train hospital people.

MR. JONES: Isn't it easier to train people for various levels of hospital jobs if you have intelligent methods worked out to teach them?

MR. CLARK: Yes, but you need the proper background before they're hired, and some understanding with the public and parochial school systems could probably help toward this.

MR. SHOOS: No one will argue that you can't do a highly technical job with an unskilled person. The proper background is required.

MR. JONES: On the other hand, the simpler you can make a routine and the more carefully thought out the written procedure is, the less time it takes to teach the individual to do the job. Isn't that true?

MR. FREDERICK: That's one of the basic points we're trying to put across here in the hospital: to review these repetitive jobs, write them down and analyze them and try to eliminate, combine or change the sequence of the operations, propose a new plan, put it in writing, teach the employe to perform the task as outlined, follow it through, and see that it's carried out as planned. It's very important that the department head accept the responsibility of seeing to it that the plan is put into effect. By doing these things we find that we have a written record of the job which can be used as a manual for training the employe and as a check list for future reference.

HOW BENEFIT SMALL HOSPITALS?

MR. CLARK: Maybe many hospitals can afford a methods department, but all of them certainly can't, and it seems to me that the larger and better equipped hospitals who do this kind of work have to make their information available to magazines and other media, so as to provide this information to the hospitals that can't have such services.

MR. SHOOS: We're getting a lot of requests for information about how to create a methods department, who operates it, where it fits into the administrative structure. People in hospital circles are evidently beginning to feel that perhaps they should be taking an active interest in this sort of thing.

MR. JONES: Isn't quite a lot of education necessary for the department heads themselves so that they understand more and more about how the methods engineer works?

MR. SHOOS: Yes, that's true. Of course, we've reached the point here where the big problem in the methods department is too much work. The department heads are constantly going to the methods department with such questions as, "Can you help me out with this?" and "What do you think about this situation?"

MR. JONES: That sounds like you've really sold the methods idea.

MR. CLARK: When progressive department heads get into the spirit of the thing, they naturally ask a lot of questions.

MR. SHOOS: That brings up another point. Sometimes when you take a look at a particular procedure or method, you find it's pretty good so you leave it alone, but at least you have it down on paper.

KEEP THE GOOD

MR. CLARK: That's right. Then you begin to separate the good from the bad. If you have something good you'd better keep it.

MR. SHOOS: At least we find out many times that hospitals do things pretty well in some respects.

MR. CLARK: I think they do and always have. I don't agree with the criticism that hospitals are inefficient. The public just doesn't understand all the many duties which hospitals have to perform.

MR. JONES: I'd like to raise another question. I doubt very much if the average hospital can save more than 5 per cent of its operating cost per patient per day, even if it has the most thoroughgoing methods study and everyone in the place, from the board of trustees and medical staff right down, is sold on it. Do you agree with me?

MR. FREDERICK: The saving in a hospital is sometimes hard to realize because we're dealing with an operation which goes 24 hours a day, seven days a week, and therefore additional personnel is required. It looks as though we have an excess of personnel on hand, although there are certain areas where we find repetitive tasks in the hospital, which lend themselves to this methods approach. It's in these areas that we are stressing methods improvements.

MR. CLARK: I don't agree on the 5 per cent.

MR. JONES: Do you think you could save more than that by thoroughgoing, well organized studies?

WHAT SAVING CAN BE EXPECTED?

MR. CLARK: Well you're talking about the engineering factor and maybe that is only 5 per cent, but there are other places where we can probably do a little bit more. We have to eliminate some of the things we've been doing which are not productive. Possibly we could get up to 8 per cent, and some hospitals will reach 12 per cent and others perhaps only 3 per cent. It depends upon the hospital. That's why this has to be done as a cooperative program in the community so that all are able to benefit by it.

MR. JONES: In this specific hospital do you think it is possible to reduce operating costs per patient per day through your type of study more than 5 per cent?

MR. FREDERICK: Well, that's kind of hard to . . .

MR. SHOOS: The picture in hospitals today is rapidly changing. We're constantly adding new services. Very rapidly we are developing special laboratories and all kinds of new diagnostic technics, and every time we add one of those laboratory procedures we add cost. You must remember that in your over-all consideration of costs. You start with one unit that operates at a certain level and then you add to it. If we aren't culling out at the other end our costs will skyrocket and the whole thing might collapse.

MR. CLARK: But do you think we're primarily interested in saving dollars? Aren't we primarily interested in getting more value per dollar? If we can run a better type of service and provide patients with better care in every respect and get them out of the hospital faster, we're not interested in whether it's going to save dollars or not. We want a greater value for each dollar we spend.

MR. JONES: Actually I'm not necessarily talking about a 5 per cent saving on the operating cost per patient per day. I'm talking about a 5 per cent saving in the patient's hospital bill, so that if by methods engineering your operations run more smoothly and you get your patient out of the hospital a little earlier, you've accomplished what I'm talking about. Does that clarify my question?

MR. SHOOS: That's true, and he gets better care while he's here. All sorts of elements enter into this thing. In industry you have competition, which means dollars. We have no competitive factor in hospitals, but we have a basic responsibility to produce good, efficient patient care, and that's something all of us have to understand.

MR. CLARK: We must go one step farther. After we find out all these things and can reduce the cost to the patient per stay in the hospital and still give him better service, we have to make him aware of this, with good public relations, and keep him advised of the progress hospitals are making. The public isn't going to take it for granted just because we say so.

TELLING THE PATIENT

MR. SHOOS: We had a good illustration of how to get this thing across right here in St. Luke's in 1953. I don't know whether or not you saw the annual report of the hospital, but I tried to call particular attention to the fact that we had about a 4 per cent increase in patients. We had in our laboratory, for example, a 16½ per cent increase in volume of work per patient. We had similar experiences in other ancillary services. The EKG department did 29 per cent more work, so there is our real cost problem. We're doing much more for each patient than we used to.

MR. CLARK: I agree with that, but are we getting it across to the patient? Magazines and all other methods of keeping the public informed have to disseminate this information so that the public understands it.

MR. JONES: One of the important aspects of your program in Cleveland is to let the public understand that we are vitally interested in reducing the cost of hospital care, and that this type of study is designed to eliminate all inefficiency that can be eliminated. If the public knows we're doing these things, it will begin to take the bill it has to pay with better grace because it will know that bill has been reduced as far as possible.

MR. CLARK: There's no doubt about that, but we have to have the cooperation not only of the newspapers and

(*Continued on Page* 138)

About People

Administrators


Dr. Roger W. De Busk

Dr. Roger W. De Busk has been appointed director of Grace Hospital, Detroit, succeeding **Dr. Kenneth B. Babcock,** who resigned to become director of the Joint Commission on Accreditation of Hospitals in Chicago. Most recently, Dr. De Busk, who takes over his duties at Grace Hospital July 1, has been administrator of Samuel Merritt Hospital, Oakland, Calif. A graduate of the University of Oregon Medical School, he was assistant director of St. Luke's Hospital, New York City, until 1941. From 1941 until 1948 he was executive director of Evanston Hospital at Evanston, Ill. During that time he was active in the Illinois Hospital Association and the Chicago Hospital Council, serving the latter organization as a board member and president. Before moving to Oakland in 1952, Dr. De Busk was administrator for three years of Lancaster General Hospital at Lancaster, Pa.

William N. Wallace, assistant administrator for medical services at Charles T. Miller Hospital, St. Paul, has been appointed administrator of that hospital. He succeeds **Dr. Peter D. Ward,** who has resigned. Mr. Wallace is a graduate of the University of Minnesota's course in hospital administration. He is a member of the St. Paul Hospital Council and the Minnesota Hospital Association.


Dr. Peter D. Ward

Elmer W. Paul, former head of Methodist Memorial Hospital, Toledo, Ohio, is now administrator of Methodist Hospital, Lubbock, Tex.

William J. Kimes, assistant director of Montefiore Hospital, Pittsburgh, is now assistant administrator of South Side Hospital, Pittsburgh. Mr. Kimes is a graduate of the University of Pittsburgh's hospital administration program and is a member of the A.H.A.

Harry W. Payne, former administrator of Plainview Hospital and Clinic Foundation, Plainview, Tex., is now administrator of the New Mexico Medical Center, Roswell, N.M.

J. L. Thomas Jr. is the administrator of Forrest S. Chilton III Memorial Hospital, now under construction at Pompton Plains, N.J., which will be opened later this year.

Norman L. Losh, who has been administrator of Orange Memorial Hospital, Orlando, Fla., has been appointed administrator of Charleston Memorial Hospital, Charleston, W. Va., succeeding **Walsh Stull,** who has resigned. **Arthur L. Bailey,** administrator of Jefferson and Hillman Hospitals, Birmingham, Ala., is the new administrator at Orlando. Mr. Bailey is president-elect of the Alabama Hospital Association, and a member of the State Planning Commission Advisory Board for Hospitals.


Norman L. Losh


Arthur L. Bailey

Adalbert G. Dierks, who was administrative resident at Barnes Hospital, St. Louis, has been named administrator of Le Bonheur Children's Hospital, Memphis, Tenn., succeeding **Freeman E. May,** who has resigned to become administrator of Baptist Hospital, Alexandria, La. Mr. Dierks is a graduate in hospital administration of Washington University, St. Louis.

John M. Danielson, former assistant director of Roosevelt Hospital, New York, is now head of North Shore Hospital, Manhasset, N.Y. Mr. Danielson has a master's degree in hospital administration from the University of Minnesota.

Arthur L. McElmurry, formerly of the University of Oklahoma Hospital in Oklahoma City, Okla., has become administrator of Nan Travis Memorial Hospital, Jacksonville, Tex., succeeding **J. D. Stoudenmier,** who has resigned.


T. Gordon Young

T. Gordon Young, assistant director of the Hospital for Special Surgery, New York, since 1942, has been named director of that Hospital. He succeeds the late **F. Wilson Keller. Warren E. Ungberg** of New York has been named assistant director.

Victor E. Costanzo, assistant director of Mount Auburn Hospital, Cambridge, Mass., has become superintendent of Harrington Memorial Hospital, Southbridge, Mass. Mr. Costanzo is a graduate of the school of hospital administration at Washington University, St. Louis.

Robert E. Trimble, who was administrator of LeFlore County Memorial Hospital, Poteau, Okla., is now administrator of Park View Hospital, El Reno, Okla., which will open in August.

Edwin A. Johns, controller at Grace-New Haven Community Hospital, New Haven, Conn., has been appointed assistant director and controller of Beth Israel Hospital, Boston. **Sidney Liswood,** who has been assistant director at Beth Israel for the last eight years, has been named associate administrator.

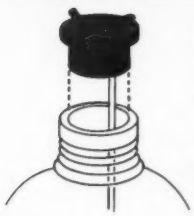
John J. McGlade, who was business manager of the Tahoe Truckee Unified School District, Truckee, Calif., is the new administrator of the Tahoe Forest Hospital at Truckee.


Arthur G. Burns

Arthur G. Burns, supervisor-hospital consultant, division of the state improvement commission, Tallahassee, Fla., has been appointed director of Memorial Hospital of Bay County, Panama City, Fla. Mr. Burns holds a master's degree in hospital administration from Columbia University. He is a member of the A.C.H.A. and the A.H.A. and is secretary-treasurer of the Northwest Florida Hospital Council.

(*Continued on Page* 174)

Mechanical umpire calls 'em "Safe" or "Out"



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Raymond Blank Hospital Guild will tell you

The Secret of Success Is Service

RUTH HACKETT WEBBER
Guild Member, Raymond Blank Hospital, Des Moines, Iowa

HERE'S a hospital auxiliary that provided $16,000 in free bed care to needy children in the last year, purchased new equipment costing more than $10,000, maintained child health conferences and an adolescent clinic, and through volunteer help added extra services to the hospital.

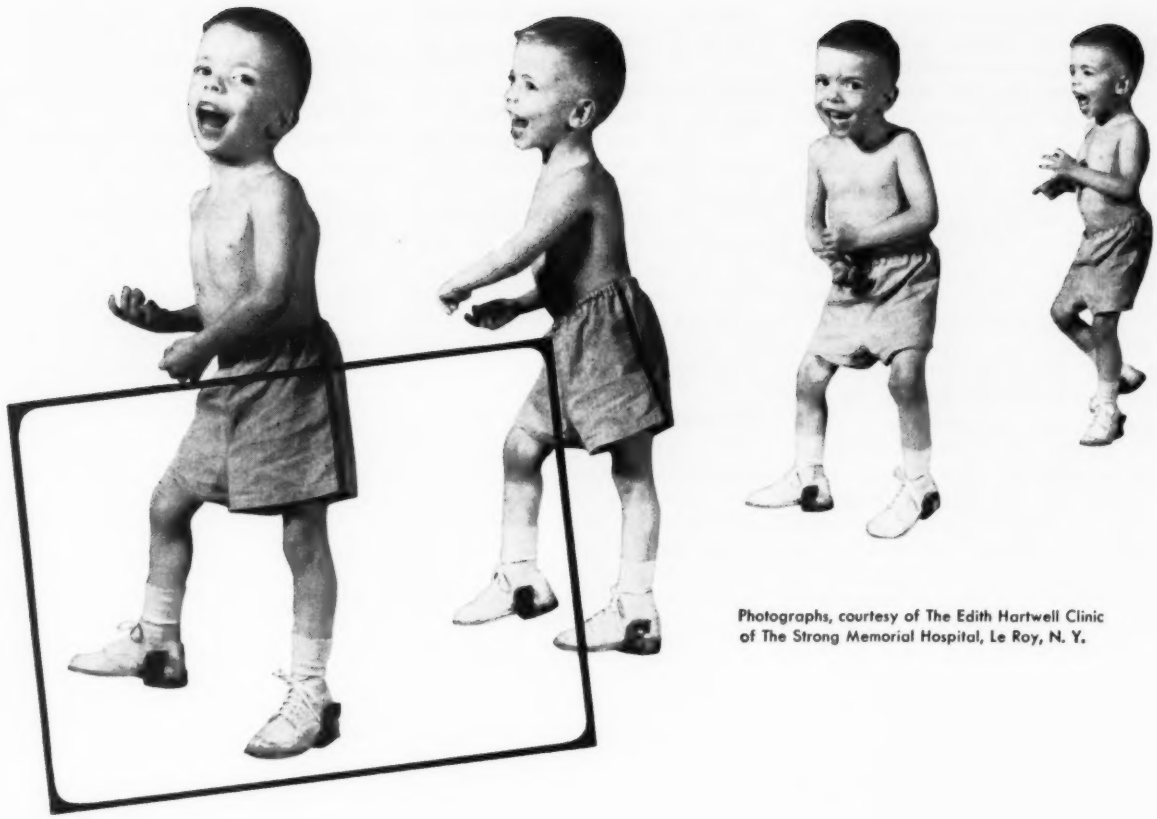
We're talking about the Raymond Blank Hospital Guild which aids in the care of children at the Raymond Blank Memorial Hospital for Children in Des Moines, Iowa, the pediatric division of Iowa Methodist Hospital.

If you were to attend one of the meetings of the board of directors of the Raymond Blank Hospital Guild you'd know why the dreams of these women are accomplished. There is an air of "let's do it—the best way possible!" that pervades the discussion of how the next drive for funds will be made, the plan for new equipment needed, and even the plans for the party they will give the nurses next month.

There are 29 women on the board of directors, 5432 members of the Raymond Blank Hospital Guild, and countless friends and supporters in Des Moines who know the value of the guild.

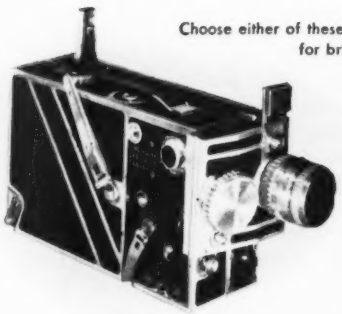
The main purpose of the guild is to provide bed care for children who would be unable to afford it otherwise. While there is a county hospital, many youngsters are not eligible to be cared for there because they are new to the city, or because their parents are in a higher income bracket. Unusual or lengthy illnesses drain a family's purse and can cause unnecessary

Here is one of the 5432 members of the Raymond Blank Hospital Guild, which in six years has become a tremendous factor in the life of the hospital and patients.



Photographs, courtesy of The Edith Hartwell Clinic of The Strong Memorial Hospital, Le Roy, N. Y.

To record motion as motion...



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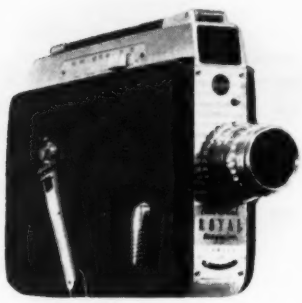

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hardship. The guild carefully investigates each case referred to it, and sees that help is given when needed.

This means that no child is turned away if he needs medical attention. It also means that this children's hospital—the only one in central Iowa—can help children with unusual medical problems, which increases the knowledge of the staff members.

Last year the guild spent $16,266 for free bed care, and for 220 children. This year it anticipates needing $20,000 for the same purpose.

New and expensive equipment is purchased for the hospital by the guild when it appears that it would be a long time before the budget of the hospital would provide it. Incubators and airlocks for premature babies, oxygen machines and diagnosing equipment, convenient eating tables, and toys for the playroom for the little tots, and many other extras increase convenience and comfort. In 1952-53 a total of $4696 was spent for equipment.

This year the guild is buying $10,000 worth of equipment to create a Blank Guild Heart Station at the hospital. This will be available to all Des Moines physicians and will be useful in the diagnosis of congenital heart defects and other phases of heart disease. The equipment will make it possible for physicians to determine whether or not surgery would be of value in certain heart cases. The equipment is also used to diagnose other emergencies.

VOLUNTEERS RESPOND READILY

Providing volunteers for hospital help is another big purpose of the Raymond Blank Hospital Guild. During the last polio epidemic more than 200 women were recruited to help the nurses. Now there is a crew of emergency volunteers, trained and ready to serve when needed. Day in and day out, volunteer workers help in the clinics, the recreation room, the admitting office, and the sewing room, working where a nurse's skill is not needed. The cherry red smocks they wear are familiar sights.

Bright cheerful clothing for the children is made by the sewing room workers. Quilts, pajamas, slippers and the like give a homey touch to hospital rooms which the youngsters appreciate.

Volunteers operate the gift shop and gift carts in both the pediatric division and in the adult division of Iowa Methodist Hospital.

Flowers to patients are distributed daily by the volunteer workers, saving time of the nursing staff. Another service is arranging for pictures of the newborn on the maternity floor.

The guild also helps in preventing illness among needy children of Des Moines by assisting in the two child health conferences held weekly. Babies and children come to receive free medical checkups and immunizations. Older youngsters are helped in the adolescent clinic. Physicians give their time for the clinics and guild volunteers help staff them.

SOUNDING BOARD FOR COMPLAINTS

The guild serves as a sounding board for any complaints from parents, and tries to do something about legitimate ones.

The guild provides the stipend for one of the eight resident doctors on duty at the hospital. It also pays for educational trips to conferences and meetings for the resident physicians and other staff members.

Frequent parties for the pediatric nurses given by the guild improve morale of the nursing staff. Each year the guild gives a $100 award to the outstanding student nurse, selected by the school's nursing faculty.

Where does the money for all these services come from? The true spirit of the directors is shown when it comes to raising funds. The drives keep everybody busy. There is the membership drive in the spring and the penny drive in the late fall.

Members are not necessarily volunteer helpers—they are simply neighbors who financially support the work of the guild. Memberships are purchased for $1, $5, or $10 and a life membership is available for $100. Last year the membership jumped to 5000, including out-of-towners.

The penny drive appeals more to the children in the community. Milk drivers in Des Moines and surrounding towns deliver the attractive collection envelopes with the daily delivery of milk, and pick them up at the end of the week. The envelopes distributed to homes are illustrated as "wishing wells" and a slot in the top invites contributors to "wish a child well." More than 75,000 envelopes are sent out. Milk bottles with posters are placed in grocery stores and restaurants. Publicity for the drive features the cooperating dairies, and the other business firms who contribute such items as posters, signs for the collection bottles, armed guard service to get the money to the bank where sacks of small change are counted. In 1953 the penny drive raised more than $10,000.

Throughout the year steady amounts of income are provided by the four wishing wells built for the guild and set up in hotel lobbies and at the airport. During state fair time the wells are taken to the fairgrounds. They bring in about $300 a month.

The service of taking baby pictures for parents at Iowa Methodist Hospital also is a source of income, realizing about $1500 a year. Profit from the gift shop and carts was about $1500 last year. Even the service of distributing flowers in the hospitals brings money to the coffers of the guild, because the discarded vases are sold back to the florists.

Another source of income is the remembrance fund. Gifts in memory of a loved one or in observance of a birthday or anniversary are put to good use through the guild.

HAS COMMUNITY RECOGNITION

With every new case helped, publicity for the guild increases. Infants are restored to health through dramatic emergency surgery; children are kept alive despite terrible burns; aid from larger medical centers is brought to the bedside of a young man suffering a rare disease—there are many ways the guild helps. People who never expected to need financial help find that the guild does not embarrass; it only gives a helping hand. The guild's name is well known in the community and reaction to it is very favorable.

The guild publishes a small news bulletin called the "Crib Sheet" twice a year, coinciding with the times of both drives. Other public relations channels are well used, such as newspaper stories, radio and television programs, speakers and exhibits.

The Raymond Blank Hospital Guild is only six years old. Its rapid increase in community services can be illustrated by the fact that in these few years its budget has jumped from $5000 to $40,000 annually.

Present leaders are Mrs. Joseph Brody, president; Mrs. Myron N. Blank, honorary director, and Mae C. Andres, honorary president.

What is the secret of the Raymond Blank Hospital Guild's success? The hard work of every member, the need it answers, and the tremendous service the guild gives.

How the administrator can help organize a

Clinical Pathological Conference

JOHN H. GORBY

Administrator, La Mesa Community Hospital
La Mesa, Calif.

AN ANCIENT philosopher wrote "He that questioneth much shall learn much." This statement is as fresh today as it was a thousand years ago. A lively spirit of inquiry has prompted the medical profession since the days of Hippocrates, Celsus and Galen. Research, study, discussion and conference—a constant drive for new methods and new applications has resulted in today's miracle of healing. The profession may not now rest on its achievements as the new technic of today will probably be obsolete tomorrow.

What is the source of this vast increase in medical knowledge? Much of it originates in the research center, the teaching hospital, and the general pooling of information through well written and well circulated medical journals. But we find little or no mention in the literature of the part played by the organized medical staffs of the 6000 hospitals of the United States.

IN COMMUNITY HOSPITAL

The staff member of a large, well departmentalized institution has frequent opportunity to discuss the problems of scientific medicine with his colleagues. What, then, of the community hospital? Has the quality of patient care declined in this group of hospitals? We think not. The medical staffs of our community hospitals are vitally interested in the continuing, never ending process of education that results in the highest standards of medical care. One method of achieving this is through the regular monthly clinical pathological conference. The problem is the actual planning for the regular monthly review of the work done in the hospital.

The requirements of a busy practice which may cover a large geographical area sometimes leave little or no time for the preparation necessary for a clinical conference. The program chairman and staff officers, engrossed with their daily problems, are able to devote little time to the preparation of the agenda for the staff meeting. The excellent material available in the hospital—even the smallest—for research and discussion is not utilized. The monthly staff meeting, therefore, generally resolves itself into a scientific paper. This type of meeting does not particularly add to the medical knowledge of the staff, nor does it meet the requirements of the Joint Commission on Accreditation of Hospitals. The staff meeting of the hospital is for one purpose only—the discussion of the clinical work of the hospital.

If the hospital has a problem of holding a clinical pathological conference, the administrator can and should do the planning for the meeting.

Much confusion exists in the minds of many administrators when the terms "clinical pathological conference" and "medical service audit" are used. They are not synonymous. The medical service audit was originated by the late Dr. Thomas R. Ponton, and first advocated by him in 1928. There have been important improvements subsequently and it has been widely adopted. The literature is quite complete, with numerous articles by outstanding authorities in the field. The purpose of the medical service audit is to study all cases treated at the hospital, medical as well as surgical. The best results from the audit are obtained when the study is conducted by a qualified person who is not a member of the staff.

DIFFERS FROM AUDIT

The clinical pathological conference, by contrast, is a discussion of the surgical work of the institution. It is conducted by the pathologist. The community hospital that does not have a full-time pathologist generally has available the services of one from a metropolitan area. Group planning may also assist a number of smaller hospitals to use this type of service on a circuit riding basis, in which a regular schedule of staff meetings is set up and the itinerary of the pathologist is carefully planned. We do this very successfully in San Diego County. The Oceanside Hospital meets on the first Monday, Paradise Valley on the first Thursday, and the La Mesa Hospital on the fourth Tuesday. We share the services of a board certified pathologist. Chart "A" on page 96 indicates the method of scheduling his work.

The conference should be conducted by the pathologist. He should serve as its chairman. We are not concerned with organization of the clinical pathological conference for our larger hospitals. These are well organized and

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well conducted. In our community hospital the pathologist (serving as chairman), the radiologist and the members of the staff may conduct a successful conference. The usual program is for the pathologist to present the physician's preoperative diagnosis and prognosis. He outlines the pertinent details of the surgical or other treatment. Consultation reports are then weighed with the evidence of the history, the physical examination, and the preoperative diagnosis. The anesthetist's record is then summarized and, finally, the report on tissue removal, both gross and microscopic. The true diagnosis is carefully explained.

At this point in the conference it is most essential that the pathologist explain carefully his reasons for perhaps differing with the diagnosis of the surgeon or the attending physician. The chief of surgical service should then comment on the technic of the operation as outlined in the operative record. This section of the conference has the side benefit of ensuring good operative records, a feature not always present in small community hospitals.

Four types of cases are presented for study. These are: (1) all surgical deaths; (2) all puzzling cases; (3) cases with complications (these would include infected surgical wounds, extreme gas distention, atelectasis, or any unfavorable details of the postoperative course), and (4) all errors in diagnosis, prognosis or treatment.

The first step to be taken by the community hospital administrator in preparation for the staff meeting should be the accumulation of the necessary data. The cases to be discussed should fall within one of the four categories listed. The first plan, Chart B, is wrong. We were led astray by this method and it took several months of very unproductive meetings before it was discovered that the object of the meeting was not being met.

Note that Chart B gives little or no basis for a determination as to the proper handling of the case. Under heading "Tissue Report" it is noted that four cases were listed as "OK." OK for what? Was the tissue normal or did it show disease? What diagnosis did the pathologist make on the case?

Chart C was the result of this experience. This indicates those elements of the case that will enable the surgical committee to pick the cases for discussion. Please note at this point that the administrator is not judging the surgical work. He is merely selecting appropriate data from the surgical record and the patient's chart.

CHART A—SCHEDULE FOR PATHOLOGIST

Monday	*Tuesday*	*Wednesday*	*Thursday*	*Friday*	*Saturday*	*Sunday*
Oceanside Staff	Oceanside	Oceanside	Paradise Valley Staff	Paradise Valley	On Call	On Call
Paradise Valley	Paradise Valley	La Mesa	La Mesa	La Mesa	On Call	On Call
Oceanside	Oceanside	Paradise Valley	Paradise Valley	Paradise Valley	On Call	On Call
La Mesa	La Mesa Staff	La Mesa	La Mesa	Oceanside	On Call	On Call

CHART B—SUMMARY OF SURGICAL WORK FOR MONTH OF JULY 1953

Hospital No.	*Surgeon*	*Procedure*	*Tissue Report*
4171	Harris	Appendectomy	OK
5129	Cole	Herniotomy	Normal
6039	Prince	Appendectomy	OK
7078	Harris	Appendectomy	Poor
7139	Harris	Hysterectomy	OK
8397	Cole	Cholecystostomy	Agrees
8742	Thomas	Hysterectomy	OK

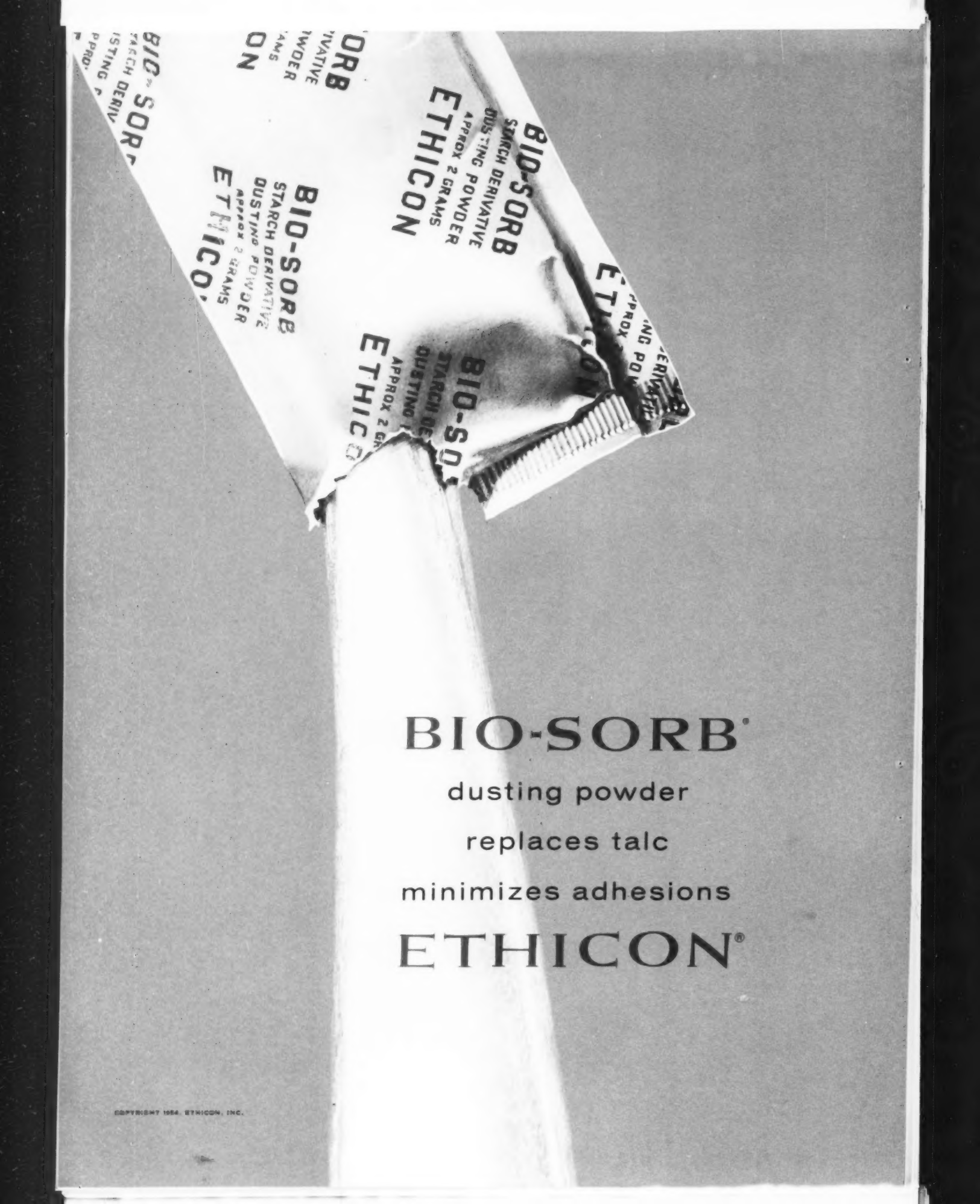
NOT TIME CONSUMING

The committee must know what the preoperative diagnosis is and whether it is in agreement with the postoperative finding. It must know the end result. A surgical death or case that does not improve should be discussed. A nonimprovement might possibly indicate faulty evaluation of the surgical risk. The column headed surgical complications is essential if infections or unusual conditions, such as Case 8742 which shows drainage for 10 days, are to be considered.

The most important feature of Chart C is the column "Diagnosis From Tissue Report." Also note in this connection that the administrator is making no decision as to whether the tissue is normal or otherwise. He is merely recording the gross diagnosis given by the pathologist. For example, Case 6039, Mild Chronic Appendicitis,

CHART C—SUMMARY OF SURGICAL WORK

Hospital No.	*Surgeon*	*Preoperative Diagnosis*	*Does Post-Op Diagnosis Agree*	*End Result*	*Complications*	*Diagnosis From Tissue Report*
4171	Harris	Appendicitis	No	Improved	None	Adhesions
5129	Cole	Hernia	Yes	Died	Infected	Perforated Colon
6039	Prince	Appendicitis	Yes	Improved	None	Mild Chronic Appendicitis
7078	Harris	Appendicitis	Yes	Improved	Infection	Gangrenous Appendix
7139	Harris	Fibroid Uterus	No	Not Improved	None	Endometrial Hyperplasia
8397	Cole	Cholecystitis	Yes	Improved	None	Cholecystitis
8742	Thomas	Ca Cervis	Yes	Improved	Drainage for 10 Days	Ca Cervis and Uterus



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might merely be a friendly euphemism for "normal tissue."

The preparation of Chart C is not too difficult. With the assistance of the surgical supervisor it takes only a few minutes each day. Its value to the committee is obvious. The administrator has now performed the detail work for the surgical committee. It is just this detail that seems to hold up the proper functioning of clinical conferences in so many hospitals.

Experience has indicated there are two additional bits of information required to aid the committee in its work. The first, Chart D, is a transcription of the evaluation of the surgical risk. This is an integral part of the preoperative study and should appear as a portion of the operative record or be filed in conjunction with it. It is only necessary to check the entry as made by the surgeon or mention that no estimate was made prior to surgery. This record is helpful in selecting cases for study. For example, if the surgeon should rate the patient as "Elective—Good Risk" and the postoperative course developed trouble, the case should be discussed. Similarly, an "Emergency—Poor Risk" that resulted in an uneventful recovery should be studied for clues to the successful technic employed by the surgeon.

CHART D—SUMMARY OF SURGICAL WORK
Evaluation of Risk by Surgeon and/or Consultant

Hosp. No.	Surgeon	Consultant	Elective			Emergency			Palliative		
			Good	Fair	Bad	Good	Fair	Bad	Good	Fair	Bad
4171	Harris	None	Not indicated								
5129	Cole	None	Not indicated								
6039	Prince	Saul	X								
7078	Harris	Emery					X				
7139	Harris	Emery								X	
8397	Cole	Jones				X					
8742	Thomas	Perry									X

CHART E—REPORT OF TISSUE COMMITTEE

Hosp. No.	Surgeon	Tissue		Does Tissue Report Agree With Diagnosis	Was Operation Justified on Basis of Tissue Report
		Normal	Pathological		
4171	Harris		X	Yes	Yes
5129	Cole		X	Yes	Yes
6039	Prince	X		No	No
7078	Harris		X	Yes	Yes
7139	Harris		X	Yes	Yes
8397	Cole		X	Yes	Yes
8742	Thomas		X	Yes	Yes

The record of the anesthetist should also be carefully studied. Anesthesiology is playing an increasingly prominent rôle in the operating room. The specialists in this field have developed procedures that make operations formerly impossible, such as work on the mitral valve of the heart, almost everyday work. The anesthetic record should contain clues as to the surgical risk and condition of the patient as the operation progresses.

The last record should be prepared for the use of the tissue committee (see Chart E). The sheet should be filled in with the case number and the surgeon's name, and the reports from the pathologist and the clinical history of the patient should be attached to it. Both records must be available to the tissue committee as it conducts its deliberations. All the detail work that can be done for these special committees by the administrator will assist them and result in complete reports for the monthly conference.

A successful meeting is a planned meeting. This means three things: agenda that are adhered to, starting on time, and closing on time—especially closing on time, even if it means leaving somebody's participle dangling in mid-air. While the administrator cannot do much about the timing of

the meeting, except by suggestion, he can and should prepare the agenda and mail them to all staff members several days in advance. Use a little originality. Do not use the dry, moribund expressions that kill the slightest interest in the meeting. The English language has more adjectives than nouns. Use them.

BAD EXAMPLE

Following is an example of poor program agenda:

6:00 p.m.—Dinner

6:30 p.m.—Business Meeting

6:45 p.m.—Case Discussion

1. Appendectomy
2. Cesarian Section
3. Cholecystectomy

9:00 p.m.—Adjournment

There is little in these agenda that would attract a doctor to attend the meeting. If he does come, it is probably a sense of duty that compels him. Observe the second example, which promises an exciting evening.

Agenda—October Staff Meeting

6:00 p.m.—Dinner
The chef has promised New York cut steaks broiled to your taste.

6:30 p.m.—Business Meeting
The minutes of the previous meeting have been mailed. The joint conference committee has had an important meeting with the trustees regarding staff membership. We want your comments on its report.

6:45 p.m.—Case Discussion

1. Appendectomy. This case turned out to be something else. It could happen to you. The surgeon presenting this case has promised to let the clues out one at a time. A perfect chance to second-guess a case that had excellent preoperative work-up.
2. Cesarian section. Some of the OB-GYN men complain that we do too many sections; others say, not enough. Follow this case—it will be presented by the chief of the service — and be prepared to argue either pro or con.
3. Cholecystectomy. Perhaps this should have been a cholecystostomy. The radiologist stands on his findings. He might weaken on cross examination.

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to the service of their patients,—a
creed and an ideal that is good
enough for any man to strive for.
W.R.

(From the writings of the late
Will Ross — October, 1914)

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and we repeat it now...

40 years later

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9:00 p.m.—Adjournment

Those of the staff who want to argue the cases further can stay as long as they like. The meeting will end at 9:00 p.m.

Some will say medicine is a serious business and doctors are dignified; they will say this notice is too flippant and sounds like circus ballyhoo. No one doubts the deadly seriousness of medicine or the dignity of its practitioners. But doctors are human beings also. There is no better antidote for the daily routine of pain and suffering than an occasional light touch, especially among the staff group itself.

The notice for the meeting should include a request that the doctor call the hospital and make a reservation. This is necessary to proper planning for a meal, if one is served. More important, it gives the administrator a list of the doctors who plan to attend the meeting. There are at least six men whose presence at the meeting is essential. They are the pathologist, surgeon, anesthetist, attending physician, and the radiologist. The reservation list enables a follow-up telephone call to remind the leaders of the conference to be present at the meeting.

A check list is helpful. A successful meeting leaves nothing to chance. A good check list would include these items:

- Agenda
- Discussion leaders
- Dinner or lunch plans
- Speakers stand
- Water pitcher and glasses
- Clinical records of cases to be discussed
- View boxes for film
- Microscope for slides
- Ask pathologist if he wants additional slides for comparison
- Medical secretary or tape recorder
- Plenty of coffee
- Extra cigarets and a few cigars
- Provision for telephone calls
- Parking space for autos—to be kept clear for emergency calls
- Director of nurses—should cases involve nursing service
- Dietitian—same reason as above

The last item of importance for the meetings is to ensure that a good secretary is present. A medical record librarian who can take shorthand at a rapid rate is the best. The secretary should be someone who understands medical terms. If the hospital does not have one, it might be possible to borrow one from the office of a staff member.

Lacking a medical secretary, the next best thing is to tape-record the entire proceedings. This may be played back enough times to help a nonmedical secretary transcribe the notes.

We are discussing the different things the administrator can do to ensure a successful clinical pathological conference. The final touch will certainly add to the administrator's popularity with his medical staff. At least we have found it so. The results of the conference are transcribed and duplicated—three cases to a page—on three-ring, round corner binder paper. Each doctor on the staff is furnished with an inexpensive three-ring binder for the reports. As each case report is indexed under case number (hospital number), diagnosis and operation, the administrator and his secretary prepare a cumulative and complete cross-index of each case each month. The master index is brought up to date in July and January of each year. Each staff member then has a completely indexed report of every case discussed at the monthly conference. The index and case reports have wide use and constant value, long after the meeting at which they were originally presented.

A number of the specialty journals do this same sort of thing. But the real value to many of the local doctors is that the staff case report is based on the complete record which is immediately available for local research purposes.

THREE-WAY BENEFIT

The benefits derived from a regular clinical pathological conference are threefold. The patient benefits because it helps to protect him against unnecessary surgery and operations by incompetent surgeons. The medical staff benefits because the conference points out errors and ways to correct them. There is a continuing medical education and the opportunity is provided for estimating the value of new drugs, methods and devices. Finally, the hospital benefits because the improved results of treating patients build the reputation of the hospital and its medical staff. This, without a doubt, is the greatest factor in good public relations. "Let your light so shine before men, that they may see your good works." (From the Sermon on the Mount. Matthew 5:16.)

Prepared by the Committee on Pharmacy and Therapeutics
University of Illinois College of Medicine, Chicago 12

MYASTHENIA GRAVIS

ALTHOUGH myasthenia gravis was first described by Willis in 1672, it was not until the end of the Nineteenth Century that the disease was characterized and studied as a clinical entity. The work of such men as Erb, Goldflam, Jolly and Oppenheim differentiated myasthenia gravis from other diseases in which skeletal muscle weakness plays a prominent rôle and permitted the definition of the disease as a chronic disease of varying intensity characterized by rapid fatigue of voluntary muscle and, in severe cases, by the failure of affected muscle groups to react even after rest. In spite of the name "myasthenia" and in spite of the usual complaint by the patient of "weakness" the disease is usually one in which the significant sign is rapid fatigability of skeletal muscle.

ONSET AND COURSE OF DISEASE

The etiology and pathogenesis of myasthenia gravis are unknown; nor do we know the genetic and environmental factors which cause a predisposition to the disease. It would appear that mild degrees of myasthenia gravis may be found not uncommonly in patients without important complaints of weakness or easy fatigability. The vagueness of the complaint of the patient, the presence of other conditions which obscure the manifestations of the disease, and inadequate facilities for differential diagnostic tests may delay definitive diagnosis; certainly it is impossible even to estimate the incidence of myasthenia gravis in the general population.

The disease may occur in either men or women at any age. In women the onset is usually in the third or fourth decade; in men there is a tendency for the disease to begin somewhat later in life. However, the disease also occurs in childhood and may even be present at birth. Myasthenia gravis may occur in either Negroes or Caucasians, but, strangely enough, the disease seems not to have been reported as occurring in members of the Oriental race.

The muscle groups affected by the disease show only fatigability and, occasionally, residual weakness after rest; the muscles are neither painful nor tender, and there are no sensory disturbances in the areas of motor dysfunction.

In general, the muscles innervated by the cranial nerves are affected first by the disease. In particular, the external muscles of the eye, the orbicularis oculi muscles and the levators of the lids are affected, and the patient manifests ptosis and weakness in closing the lids and a varying degree of external ophthalmoplegia; the patient may complain of ptosis and blurring of vision or diplopia, particularly after reading. As other muscles innervated by the cranial nerves are affected, the patient develops an expressionless, mask-like face, dysphagia and difficulty in chewing, dysphonia and a "nasal" voice, and even difficulty in holding his head upright. In a small number of patients, the disease does not progress beyond the stage of ocular myasthenia.

When the limbs are involved by the disease, the upper extremities are usually affected before the lower, and the proximal muscles are affected before the more distal muscles. (The patient may complain of such things as the inability to raise his arms in order to comb his hair.) In the upper extremity the extensor muscles seem to be involved earlier in the course of the disease than the flexor muscles; the reverse of this condition obtains in the lower extremity. Eventually, as the disease progresses, the muscles of the trunk and of respiration become involved, and finally even the diaphragm is affected and death may occur because of respiratory failure.

Characteristically, only skeletal muscles are affected by the disease; there is no evidence that myasthenia gravis affects any other system or organs, and the function of cardiac and smooth muscle is undisturbed even in the most serious cases. (Hyperthyroidism, however, occurs more frequently in patients with myasthenia gravis than it does in the general population.)

In Grob's[1] series of 202 patients with myasthenia gravis about 25 per cent of the patients experienced remissions of their disease lasting from six months to 17 years; the average length of the remissions was about four and one-half years. However, it would appear that, in general, about 25 per cent of all patients with myasthenia gravis die within five years of the onset of the disease. Since such patients usually die of respiratory failure because they have become refractory to their therapy, and because of intercurrent diseases such as pneumonia, it is to be hoped that more specific therapy of myasthenia gravis and the use of such drugs as antibiotics may eventually diminish the mortality rate in myasthenia gravis.

In considering the prognosis for any given patient, it must be remembered that any physical or psychological stress tends to increase the severity of the disease. Although there may be a remission of the disease during the third trimester of pregnancy, there is an equal probability that the disease may become worse; during the postpartum period, there is often an exacerbation of the disease. Certainly the appropriate therapy of myasthenia gravis must be more than symptomatic relief of muscle fatigability and weakness.

The pathological findings in a patient with myasthenia gravis are few

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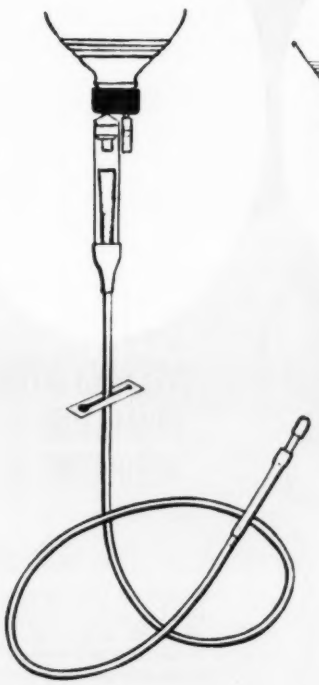

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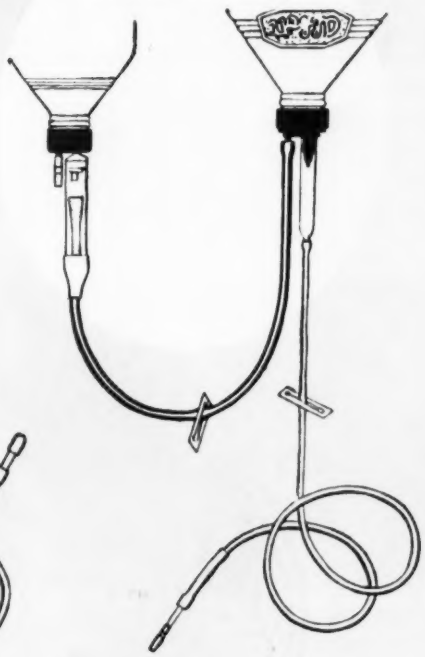

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and difficult to relate to the course and outcome of the disease.

Characteristically, the muscle cells are found to be histologically normal; there is no evidence of atrophy, hypertrophy or replacement of muscle cells by fibrous or fatty tissues. Both peripheral nerves and the central nervous system are found to be normal. A finding reported by Buzzard in 1905, and confirmed by many investigators since that time, is the presence in the muscles of lymphocytic infiltration; the small aggregates of lymphoid cells are known as "lymphorrhages" and have been found in the liver, the thyroid gland, and adrenal glands, as well as in the muscles of patients with myasthenia gravis.

The thymus gland has frequently been shown to be abnormal either grossly or histologically, or both. The most frequent abnormality is the persistence in the adult of a "juvenile" thymus gland. In such cases the gland is grossly larger than normal and histological examination reveals the presence of lymphoid hyperplasia and the presence of germinal follicles in the medulla. In about a third of the cases that have been reported an actual thymoma has been found.

TREATMENT

The drug most frequently used in the treatment of myasthenia gravis is neostigmine, which acts presumably by inhibiting acetylcholinesterase at the skeletal neuromuscular junction; such an action facilitates neuromuscular transmission by permitting the "accumulation" of acetylcholine at the junctional region. Neostigmine is usually adminstered by mouth, three or four or more times a day, in a quantity sufficient to abolish the symptoms referable to skeletal muscle; parenteral administration of the drug is usually reserved for times of emergency. Since neostigmine inhibits acetylcholinesterase throughout the peripheral nervous system, it is occasionally necessary to use an adjunctive drug such as atropine or tincture of belladonna to mitigate symptoms, such as abdominal cramps, diarrhea, siallorrhea and disturbed visual accommodation, which are referable to parasympathomimetic effects of neostigmine.

Some of the so-called "irreversible" inhibitors of cholinesterase such as tetraethylpyrophosphate (TEPP) and octamethylpyrophosphoramide (OMPA) have been used in the treatment of myasthenia gravis. In general, the great potency of these compounds and their long duration of action, as well as the undesirable side effects seen with such drugs as TEPP (anxiety, insomnia and nightmares), have prevented routine use of the drugs.

Such agents as ephedrine, quanidine, and potassium chloride have proved to be useful adjuncts to neostigmine therapy in an occasional patient, but can seldom if ever be used alone to control the disease. The early hope that the adrenocorticotropic hormone or cortisone might be of value in the treatment of myasthenia gravis has not been fulfilled; if anything, the use of these hormones increases the severity of the disease.

The value of thymectomy and X-irradiation of the thymus gland in the treatment of myasthenia gravis is still being debated. Some investigators are enthusiastic about the results of the procedures; others find no evidence that the procedures influence the course of the disease at all. Some investigators find that the removal of thymomas frequently results in remission of the disease; others find that removal of thymomas has little effect,

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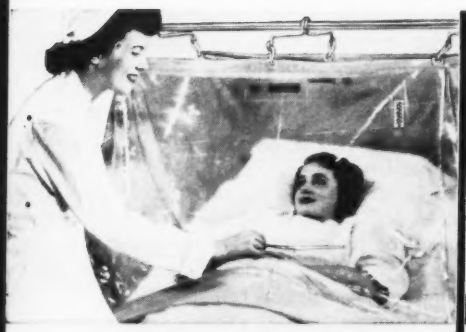

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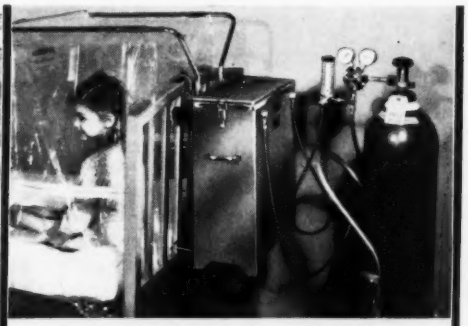

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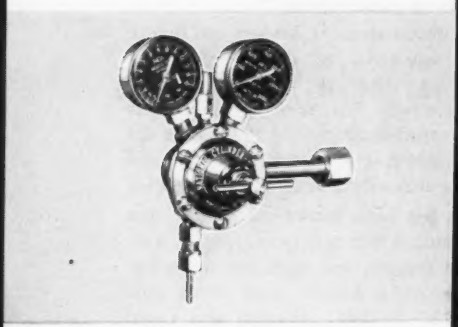

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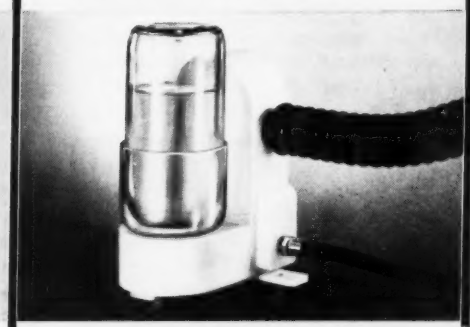

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but that the removal of a hyperplastic thymus gland may result in a remission. Schwab and Leland[2] believe that thymectomy is indicated in females, particularly in the younger age groups, but that the operation is contraindicated in males; these workers base their conclusions on the results in a series of 78 thymectomies, compared to the outcome of the disease in a series of 78 who received only medical therapy.

PATHOPHYSIOLOGY

Several clinical observations provide a frame of reference within which to discuss the pathophysiology of myasthenia gravis. Jolly was the first to characterize the so-called "myasthenic reaction": the rapid fatigue of a muscle stimulated tetanically through its motor nerve. This observation was supplemented by that of Buzzard, that a muscle fatigued in such a way was still able to respond with contraction to direct stimulation of the muscle by a galvanic current. The inevitable conclusion is that the primary seat of the pathology is not in the muscle fiber per se. A second important observation was that of Mary Walker: If the venous outflow from a limb affected by the myasthenic process be occluded and the limb be exercised to exhaustion, sudden admission of the blood from the limb to the general circulation results, in many cases, in transient increased fatigability in muscle groups which were previously unaffected. The conclusion that a "something" which can enter and leave the general circulation and be transported in the blood is responsible for the myasthenic reaction is supported by the observation that occasionally a child born of a myasthenic mother will have a typical myasthenic syndrome which lasts through only a few days of postnatal life.

The clinical characteristics of the disease lead us to the conclusion that myasthenia gravis is a disease in which the fundamental defect appears to be a failure of nerve impulse transmission at the skeletal neuromuscular junction. Our knowledge of neuromuscular physiology incorporates three factors which could account for this failure: (1) Amounts of acetylcholine inadequate to stimulate the muscle might be produced at the nerve terminals. (2) An excess of cholinesterase might hydrolyze acetylcholine produced in normal amounts before it was able to stimulate the muscle. (3) A substance or process at the neuromuscular junction might elevate the threshold of otherwise normal muscle fibers to acetylcholine reaching the junction in normal amounts.

There is no evidence that acetylcholine is produced in quantities smaller than normal in the patient with myasthenia gravis; certainly there is no evidence of dysfunction at other sites in the peripheral nervous system at which acetylcholine is presumed to have an important function. Neither is there evidence that either in quantity or efficiency the cholinesterase in tissues or blood of the patient with myasthenia gravis differs from that in the normal subject.

Similarities between the myasthenic process and curarization have been summarized in detail by Harvey and Lilienthal.[3] In brief, both the disease and the drug prevent an affected muscle from maintaining a tetanic contraction. Both the disease process and the drug effect are reversed by such anticholinesterase drugs as neostigmine and TEPP. The muscle groups affected by the disease are affected in the same order, as the disease progresses, as they are affected by progressively larger doses of tubocurarine.

Tubocurarine is known to reduce the sensitivity of muscle to acetylcholine. Engbaek has demonstrated conclusively that in myasthenia gravis the muscles affected by the disease are less sensitive to acetylcholine injected intra-arterially than are normal muscles.

It has been known since 1937 that quinine, which acts synergistically with tubocurarine, will aggravate the symptoms of a patient with myasthenia gravis. In 1943, Bennett and Cash[4] demonstrated that patients with myasthenia gravis were 10 to 20 times as sensitive to the effects of tubocurarine as were nonmyasthenic patients. Recently it has been demonstrated that the mean threshold dose for minimal curarization of the extraocular muscles of patients with myasthenia gravis was 5.4 micrograms/kgm., and that the corresponding dose of tubocurarine in normal subjects was 24.8 micrograms/kgm.[5] It is obvious that the disease process and the drug act synergistically with each other.

Tubocurarine acts to prevent depolarization of the cell membrane of skeletal muscle by acetylcholine. Other drugs which produce paralysis of skeletal muscle (drugs such as decamethonium and succinylcholine, for example) act by producing a prolonged and intense depolarization of the skeletal

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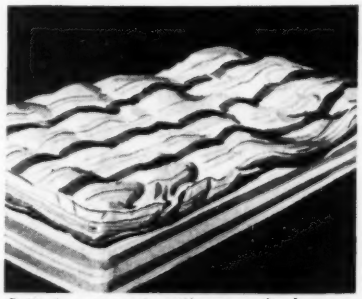

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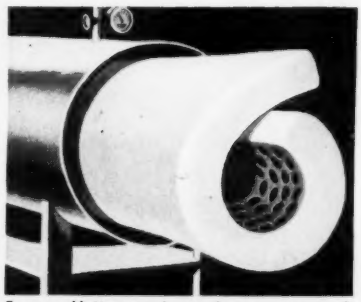

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muscle cell membrane. It has been demonstrated in animal experiments that, consistent with their respective modes of action, a real, albeit limited, mutual antagonism exists between the actions of tubocurarine and decamethonium. In an attempt to investigate further the similarities between myasthenia gravis and curarization, the effects of decamethonium were measured in patients with myasthenia gravis. It was found that not only was the sensitivity of the extraocular muscles to decamethonium the same in the patients and in normal subjects (4.5 to 5.5 micrograms/kgm.), but the administration of decamethonium produced a transient amelioration of symptoms in the patients with myasthenia gravis.[5] Similar effects of decamethonium in myasthenic patients have been observed by Churchill-Davidson and Richardson using an electromyographic technic to analyze skeletal muscle function.[6]

In general, the effects of decamethonium on the muscle affected by myasthenia gravis are the same as the effects of the drug on a muscle partially curarized by tubocurarine.

The concept that a blood borne substance having many of the properties of tubocurarine is responsible for the signs and symptoms of myasthenia gravis has led a number of investigators to search for such a substance in the blood of patients with myasthenia gravis. Wilson and Stoner reported that the serum of such patients had a tubocurarine-like effect on isolated frog muscle, but subsequent investigations have failed to confirm their result. Recently, Schwarz has demonstrated that the transfusion into a normal subject of up to 1500 cc. of blood from a patient with myasthenia gravis had no effect on the muscular strength of the normal individual; neither did an exchange transfusion of 4000 cc. of blood from a normal subject into a patient with myasthenia gravis affect the strength of the patient.[7] Schwartz did find, however, that intramuscular injection of serum from a patient with myasthenia gravis into the arm of a normal subject was succeeded by a weakness of that arm; this weakness was relieved by neostigmine, and serum from a normal subject had no such effect as did the serum from the patient. Should this result be confirmed, it might be significant that the "test-animal" is of the same species as the donor of the serum; one might then consider the possiblity that the material responsible for the symptoms of myasthenia gravis might in fact be a species specific material.

Until further investigations concerning the pathophysiology and the pathogenesis of the disease are completed we must be content to say that the pathophysiological findings in myasthenia gravis are consistent with the presence at the neuromuscular junction of a process or substance which decreases synaptic transmission. The substance or process acts in a manner similar to that of tubocurarine in decreasing the muscular response to acetylcholine. Furthermore, there is some evidence that a substance with such properties may be present in the blood stream of patients with myasthenia gravis.

DIAGNOSTIC CONSIDERATIONS

It may happen that the clinical history and physical examination of a patient suspected of having myasthenia gravis are inadequate to permit a definitive diagnosis; several methods using diagnostic drugs may aid in differential diagnosis.

Drugs which provoke or intensify

the signs of myasthenia gravis may be administered. Harvey and Whitehill have recommended the use of quinine in such a manner; unfortunately, since the sensitivity of the patient to the drug is not known *a priori*, the use of a fixed, oral dose of quinine could conceivably lead to considerable discomfort in a patient who proved to be extremely sensitive to the drug. The intravenous administration of a fixed dose of tubocurarine (equivalent to a dose of tubocurarine of 7.5 to 15 micrograms/kgm.), as recommended by Bennett and Cash,[4] is subject to the same objection, even though the effects of an inadvertent overdosage could be counteracted by the administration of neostigmine. A provocative test which produces a minimum of discomfort for the patient consists of the administration by a timed interrupted infusion technic of tubocurarine at a rate of 1.5 micrograms/lb./minute; the end point in the test is the recession of the near point of binocular convergence because of the effect of the drug on the extraordinarily sensitive extraocular muscles.[5] Overdosage using this test is almost impossible because the controlled rate of drug administration permits modification of the dose according to the response of the patient, and permits a quantitative assessment of the sensitivity of the patient to the drug.

The physician may elect to use a therapeutic trial, rather than a provocative diagnostic test, to aid in the diagnosis of myasthenia gravis. Neostigmine may be administered orally, intramuscularly, or intravenously in such a trial; disappearance of the patient's symptoms and signs, of course, constitutes a positive response to the test and supports the diagnosis of myasthenia gravis.

A modification of this test is that suggested by Osserman and Kaplan, in which the anticholinesterase drug to be injected is edrophonium (Tensilon) the action of which differs from that of neostigmine chiefly in the rapid onset of action and brief duration of action of edrophonium and its minimal effects in producing symptoms referable to parasympathomimetic activity.

Needless to say, the results of diagnostic tests are inconclusive by themselves, and gain significance only insofar as they confirm or deny the diagnostic impression made on the basis of the course of the disease and the physical examination. For example, in a series of 32 normal subjects, the sensitivities of the extraocular muscles to tubocurarine was found to be abnormally low in 4 per cent of the group: that is the extraocular muscles of about 4 per cent of the general population may be predicted to be as sensitive to the action of tubocurarine as are the extraocular muscles of the average patient with myasthenia gravis. Similarly, the extraocular muscles of 3 to 4 per cent of patients with myasthenia gravis will be found to be no more sensitive to the effects of tubocurarine than are the extraocular muscles of normal individuals.

The varying sensitivities of normal individuals to the effects of tubocurarine and the exquisite hypersensitivity to the drug of patients with myasthenia gravis must be considered when tubocurarine is used in therapy and in anesthesiology. About 4 per cent of "normal" patients may be found to have an abnormal sensitivity to the drug; in such persons one or more muscle groups may be totally paralyzed by a dose of the drug calculated to produce even only minimal effects in a normal subject. It should be emphasized that tubocurarine can be used with safety only when a preliminary test dose of the drug is given to assess the patient's sensitivity to it, and when facilities for the administration of positive pressure artificial respiration and appropriate drug antagonists are available.

SUMMARY

Myasthenia gravis is a disease of unknown etiology and pathogenesis characterized by rapid fatigability and weakness of skeletal muscle. How many of the multitude of patients who complain of weakness have this disease is unknown. Simple diagnostic tests permit the differentiation of myasthenia gravis from other diseases. Therapy consists of treatment with anticholinesterase drugs of which neostigmine is the outstanding example.—EDWARD W. PELIKAN, M.D.

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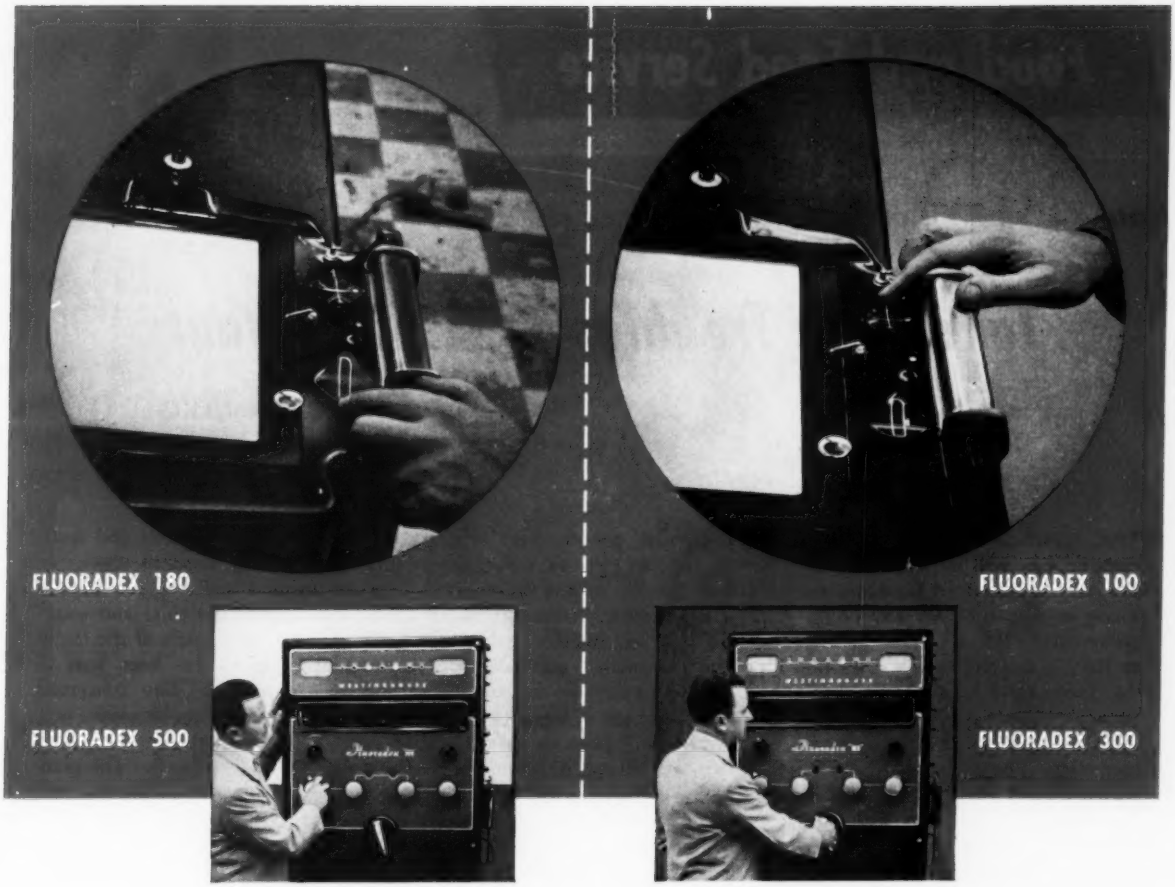

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In answer to doctors' problems of equipment complexity, Westinghouse introduces the Westinghouse twin tables and twin controls. The Fluoradex 180 and the Fluoradex 100 are identical in every detail except that one tilts through 180° while the other offers up to 10° Trendelenburg tilt. The Fluoradex 500 and the Fluoradex 300 offer identical controls except that one is rated at 500 MA, the other at 300 MA.

These twin tables and controls can be placed in adjoining rooms, and they relieve the radiologist of equipment consciousness as he moves from room to room. The technician, too, is relieved of the necessity of handling totally different types of controls. Departmental efficiency is increased markedly by this room-to-room uniformity.

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Note to Small Hospitals:

Take Your Troubles to a Consultant

MARGARET DYKES

Dietary Consultant, Division of Hospital Services
Georgia Department of Public Health, Atlanta

THE construction of new hospitals under the Hill-Burton program has caused a greater need for dietitians in Georgia. Almost 80 per cent of the approximately 250 hospitals in the state have a capacity of less than 50 beds. There are a limited number of trained dietitians available, and the salaries offered are usually too low to attract them. The division of hospital services of the state department of public health is the agency that handles the Hill-Burton funds for the construction of new hospitals. This division has a dietary consultant as a member of the staff, employed to work primarily with the smaller hospitals in the state which do not have qualified dietitians.

The dietary consultant for the smaller hospitals in Georgia is an active member of the American Dietetic Association. Her job description specifies that she must have had experience as an administrative dietitian as well as teaching experience in nutrition and diet therapy.

Duties of the dietary consultant include assistance in planning dietary departments for new hospitals. After a community makes application for Hill-Burton funds, a survey is made by the division of hospital services to help the community determine whether or not it needs and can support a hospital. After the application for funds is approved, the community employs an architect who first makes a schematic drawing of the proposed building. This drawing is submitted to the division of hospital services to be checked. The dietary consultant is asked to check the plan for the dietary department. Following this step, blueprints and equipment specifications are reviewed and suggestions for changes are made before contracts for construction are awarded. Assistance in remodeling kitchen and dining facilities in existing hospitals is also given when requested. This includes the rearrangement and selection of equipment.

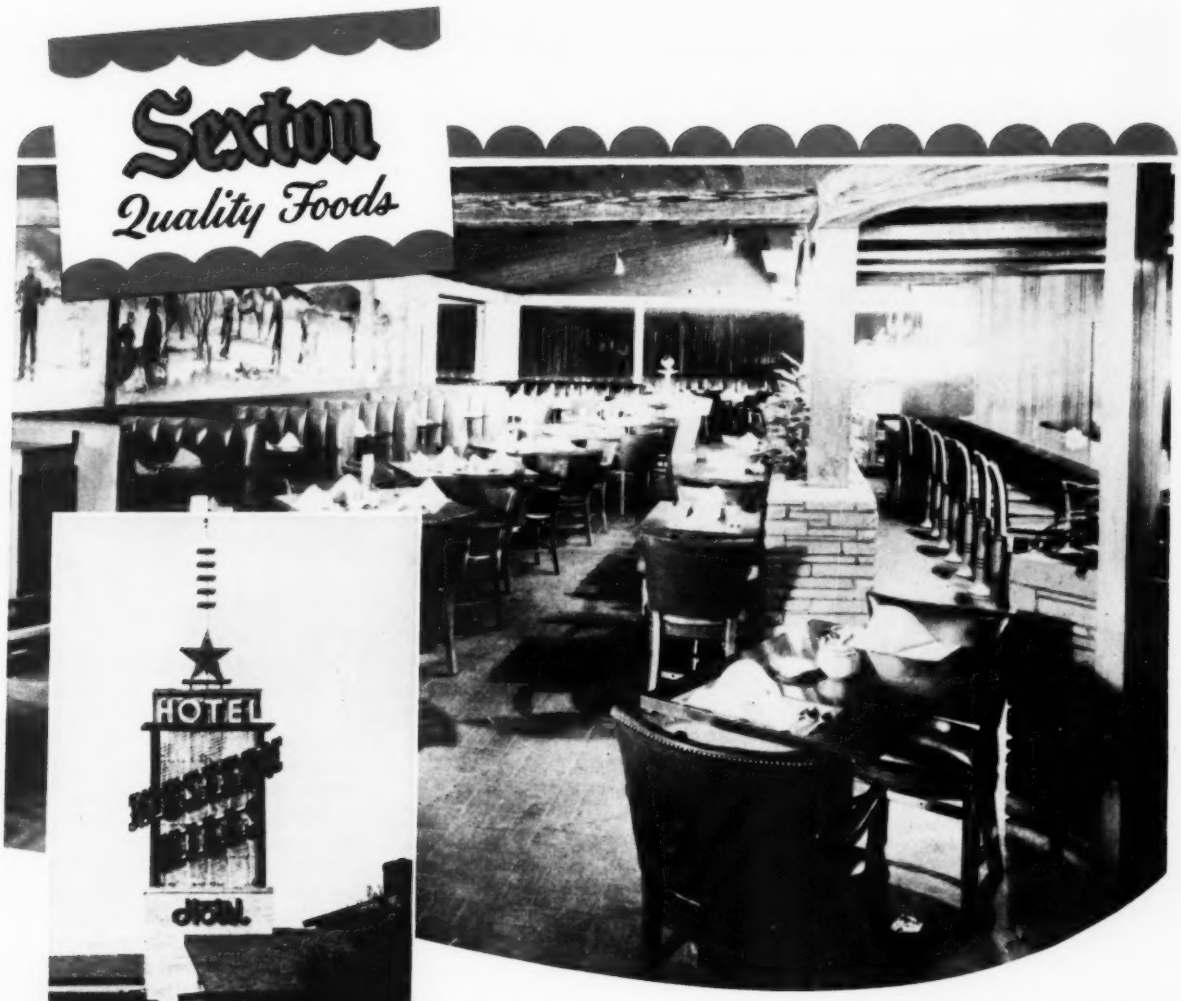
A few months prior to opening the hospital, a meeting is arranged between the hospital board of trustees, the administrator, and representatives of the division of hospital services. The various specialists and consultants participate in this meeting. Various aspects of hospital operation are discussed, including those which need to be considered before opening date. The dietary consultant briefly discusses operation of the dietary department at this meeting.

Another visit is usually made just before the opening of the hospital after the equipment is installed and the food service supervisor is on duty. If such a visit cannot be scheduled before opening date, it is made as soon as possible thereafter. During this visit, an effort is made to help the food service supervisor with various areas of dietary operation, particular attention being given to problems or questions which have arisen. A return visit is made a few months after the hospital opens, usually at the request of the administrator. Assistance in dietary operation is also given to existing hospitals.

The dietary consultant served as coordinator in the development of a diet manual for the smaller hospitals in Georgia. A committee of physicians and trained dietitians worked together on this project. The manual has been distributed to all hospitals and nursing homes in the state, to physicians on the medical staffs of the smaller hospitals, and to the chief and secretary of the medical staffs of the larger hospitals. Copies have been sent to the agency in each state concerned with the hospital construction program. A limited number is available for out-of-state distribution. The planning and development of training programs for food service supervisors are also duties of this consultant. For the last two summers, the school of home economics at the University of Georgia and the division of hospital services have jointly sponsored one-week dietetics workshops for food service supervisors in the smaller hospitals. Some work has been done on the planning of in-service training programs for dietary personnel.

Attendance at state and national meetings and participation in professional organizations are part of the program of the dietary consultant. Necessary office administrative work is also included in her duties.

The procedure followed in scheduling dietary consultation service is handled in one of several ways. A request for assistance is usually made by the hospital administrator either by letter or telephone call. The consultant, in turn, requests the administrator to inform the food service supervisor of her future visit. The consultant also inquires as to the nature of help needed. This assists in the selection of material needed when the visit is made. Requests for consultation are frequently made through other staff members who visit hospitals. All requests are checked with the division director and



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JOHN SEXTON & CO., CHICAGO. 1954

other staff members to determine whether there is any general information which the consultant should have before making visits.

The areas of dietary operation in which help is most frequently requested are the following: financial control, including food costs and personnel requirements; menu planning and food purchasing; modified diets, recipes and portion control; selection and rearrangement of equipment following remodeling in existing hospitals, and survey of entire operation.

When a hospital visit is made, the dietary consultant first meets or confers with the administrator. Following a discussion of problems as they appear to the administrator, he then introduces the consultant to the food service supervisor. An effort is made to impress the administrator with the idea that the consultant is there to be helpful and not merely critical. Because the food service supervisor may feel concerned about the visit, it is important that the consultant try to establish a friendly atmosphere before discussing the operation of her department. Even though it may mean discussing topics which are irrelevant to the problem, it seems imperative that the consultant make every effort to dispel any feeling of insecurity or fear of criticism which may exist. At no other time in the daily work of a dietary consultant is it so important for her to say the right thing at the right time. Once the food service supervisor feels that the consultant wants to be helpful, they can proceed to a discussion of the operation of the dietary department.

It always seems advisable to proceed in a leisurely manner, occasionally asking pertinent questions and making tactful comments concerning the problems which may have previously been mentioned by the administrator.

An effort is always made to speak to the food service employes briefly as a group although it is not a good idea to discuss problems with them as individuals. If, however, they ask questions about how to do something or the supervisor requests the consultant to work with them, help should then be given. If by any chance the employes criticize the supervisor or other hospital staff members, it is certainly advisable to refrain from discussing their employers with them.

After observation and discussion, the consultant talks with the food service supervisor about suggestions which will probably be made in a written report. In this way, she knows more definitely how to interpret the suggestions which are made.

If there is any apparent friction between or among the hospital staff members, it is important to discuss all questions from an objective point of view. This is sometimes rather difficult.

If possible, it is a good idea to talk with the administrator again before leaving the hospital and say that a written report will be forthcoming. This affords further opportunity to discuss suggestions with him. An offer to make a return visit is made and it is suggested that questions be referred to the dietary consultant by letter or telephone when help is needed.

After the consultant returns to headquarters, a written report or letter is sent to the administrator. A copy of this is sent to the food service supervisor and a copy is kept on file in the office.

In my opinion, a dietary consultant for the smaller hospital should, first of all, like people and enjoy working with them. She should be a person whose professional ethics are so well developed that the untrained food service supervisor will not hold the consultant at arms' length because of her so-called superior knowledge but will feel that she is just like other people. Diplomacy on the part of the consultant is imperative if her knowledge of dietetics is to be of any value. Tact, too, must be a deep-rooted characteristic if she is to accomplish desired results. Above all, discretion should be used when personal differences exist in the hospital. Good judgment and the ability to make sound decisions when situations call for clarification enable her to render more valuable service. But it is always better to say, "I do not know but I will get the information for you," than to give an uncertain and possibly erroneous answer.

The dietary consultant for the smaller hospital should possess physical stamina because her work is strenuous. She should realize that, of necessity, her program is a long-term one. Results seldom are immediately apparent. Actually the dietary consultant needs to be all things to all men—dietitian, architect, diplomat, engineer, accountant, food service director, cook and kitchen helper! But it is a challenging job because the need is great. Being a dietary consultant is the most interesting work I have ever done.

See the Catalog of Blickman-Built Food Conveyors in the Hospital Purchasing File.

Peaches Rate an A—as in Provitamin A and Ascorbic Acid

ILMA LUCAS DOLAN
California Foods Research Institute, San Francisco

PEACHES have an ancient heritage. The books of Confucius, five centuries before Christ, mention peaches. Some authorities maintain that the cultivation of peaches in China has been traced to the Tenth Century, B.C. Nearly 2300 years ago Theophrastus mentioned the prunus persica as a delectable fruit from Persia and from thence it made its European debut at about the beginning of the Christian era. By the middle of the Sixteenth Century peaches apparently reached England and peach stones were ordered from England by the governor of the Massachusetts Bay Colony in 1629.

The epoch making event was the successful preservation of peaches by Nicholas Appert in France around 1810. Even in those days skilled technics had ready acceptance, and by the time our Civil War was under way, peaches were being canned in Delaware and Maryland. By 1900, peaches migrated from the Atlantic to the Pacific shores.

Peach growers assisted by the University of California and federal agencies are now producing four varieties of cling peaches ideal for canning—selected according to ripening time, beginning in mid-July, ending in mid-September.

Peaches are harvested by hand when they reach maximum size and maturity. Great care is taken to avoid bruising, several pickings are made, and peaches are hurried through various processing steps to preserve their color, flavor, texture, nutritive qualities and beauty.

Cling peaches come in three sizes: fancy, choice and standard. The sizes vary from season to season but the largest are called fancy, the next in size, choice, and the smaller peaches, standards. Sirups also enter into these designated sizes. The fancy pack has a heavier sirup, with a higher sugar content than choice or standard grades. Most peaches are packed in No. 2½ tins for family use, and convenient No. 10 tins for institutional use. Fruit cocktail which contains cubed peaches, as well as pears, grapes, pineapple and cherries, comes in similar packs.

Whether we live to eat or eat to live, the good or bad appearance of meals is an important factor. For eating pleasure, there are few things equal to a serving of canned cling peaches, aside from their provitamin A, ascorbic acid and niacin content. Their cheerful glow uplifts jaded appetites and the golden fruit, served just as it comes from the can, makes friends and happy patients. But there are countless other ways to use this fruit. Following are some appetizing combinations.

Sliced canned cling peaches atop a bowl of hot or prepared cereal.

(*Continued on Page* 120)

Whether it is served hot or cold, any cereal tastes better when it is crowned with some colorful canned peach slices.

Canned fruit cocktail, accented with wedges of fresh oranges and served in orange cups, stimulates appetites.

TWO GOOD REASONS Why More Restaurants Use Heinz Than Any Other Pickles!

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You Know It's Good Because It's HEINZ!

Broiled canned cling peach halves dotted with butter and honey, served with French toast or hot cakes.

Diced canned cling peaches added to muffin or waffle batter.

Cocktails:

Canned fruit cocktail with cubes of avocado.

Sliced canned cling peaches, thin strips of unpeeled red apple and cubed pears combined with peach sirup and a dash of Muscatel wine.

Sliced canned cling peaches crowned with partially frozen peach sirup sparked with lime juice.

Meat Garnishes:

Canned cling peach halves brushed with butter, filled with maple sirup and broiled.

Canned cling peach halves brushed with butter, filled with catsup and broiled. (This may sound odd, but it's delicious.)

Canned cling peach halves filled with mayonnaise and chopped ripe olives and broiled.

Canned cling peach halves spiced with whole cloves, stick cinnamon and baked with brown sugar in a moderate oven.

Salads:

Canned cling peaches, slices or halves, molded in flavored gelatin.

Canned cling peach halves filled with cream cheese, raisins and chopped nuts.

Canned cling peach slices, cubed, combined with shredded cabbage and sour cream dressing.

Canned cling peach halves filled with a walnut stuffed prune and a lemon-honey dressing.

Two canned cling peach halves put together sandwich fashion with sieved cottage cheese mixed with minced onion.

Desserts:

Individual meringues filled with canned cling peach halves, garnished with strawberries.

Ice cream served with peach slices and cinnamon-flavored peach sirup, slightly thickened.

Cottage pudding with sliced canned cling peach-butterscotch sauce.

Sliced canned cling peach and raisin pie.

Individual baked peach cup custards.

Plain puddings crowned with canned cling peaches.

Upside down canned cling peach gingerbread.

FOOD FOR THOUGHT

Beef Kabobs

In the United States, according to a dictionary definition, a cabob (or kabob) is a strip of beef and a slice of bacon wrapped around the end of a green stick and roasted over an open fire. It is usually garnished with sliced onions.

To make "Beef Kabobs on Skewers," cut beef steak into 1½ inch cubes. Alternate cubes on skewers with thin slices of raw or parboiled onion, bacon, firm tomatoes, mushrooms, green peppers. Roll the filled skewers in melted butter or margarine. Broil in range broiler, turning to cook evenly on all sides. Season. Allow about 18 minutes for beef kabobs rare, about 25 minutes for well done.

Meat Loaf

Another suggestion for these days of plentiful supplies of the less expensive cuts of beef is meat loaf. Make it ahead, serve it hot or cold.

Ingredients are 2 pounds of ground beef, ½ cup chopped onion, ¼ cup chopped celery, ¼ cup chopped parsley, pepper to season, 1 cup soft bread crumbs, 1 cup milk or canned or cooked tomatoes, 1 egg, beaten, and 1 teaspoon salt.

Mix all ingredients together thoroughly. Pack mixture into a loaf pan. Bake at 350 degrees F. (moderate oven) about 1½ hours. Serve hot or cold. This recipe makes 10 servings.

Speedier Vegetable Preparation

Short cuts in preparing vegetables are well worth consideration. When you wash spinach or other greens, for example, place them in a big pan or sinkful of water, pat them gently to loosen grit and soil without bruising leaves, then lift them out instead of *draining* the water off. This way, you lift them from the settled soil.

To remove silk from sweet corn, use a vegetable brush instead of pulling off each strand with the fingers. To hold an ear of corn steady for cutting off the kernels, impale it on the sharp end of a nail driven through a cutting board. If you prepare corn in quantity for freezing or canning, it may pay to use one of the curved cutters designed especially for the purpose.

If you must pare vegetables, one of the best hand utensils is the little inexpensive swivel-type peeler. It works fast, pares thin, and prevents waste.

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Embossed Paper

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To brighten up tray service, to lighten cost burdens, look to embossed paper tray covers like "Rose Linen", another popular design by Milapaco. This attractive tray cover, with matching doily, faithfully simulates in paper the delicacy and texture of real linen.

In linen — or any of many distinctive lace or stock and special print designs — Milapaco tray covers add welcome "meal appeal" to hospital tray service . . . always fresh, clean and sanitary . . . used once and discarded to reduce contamination . . . extra soft to prevent sliding, absorb spillings and reduce noise from the clatter of china and utensils.

A proven economy, too, Milapaco tray covers cost but penny-fractions per serving . . . come in a wide range of sizes to fit any tray . . . cut linen costs . . . reduce laundry-labor expense . . . save wear on trays . . . speed up service . . . and store compactly.

The happy touch for the patient — and the dietitian and purchasing agent, too — Milapaco tray covers are indeed a "preferred stock." And for all your specialty needs, look to the famous Milapaco family, a complete dependable source of quality specialty paper products.

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Menus for August 1954

Celia Whitt
Dietitian
Deaconess Hospital
Freeport, Ill.

1 Grapefruit Half Bacon, Coffee Cake • Chicken Noodle Soup Fried Spring Chicken Mashed Potatoes, Cream Gravy Green Beans, Almonds Jellied Bing Cherry Salad Vanilla Ice Cream With Fudge Sauce • Spring Soup Creamed Ham and Mushrooms Over Asparagus Soufflé Twin Mountain Muffins Red Raspberries, Cream	**2** Honey Dew Melon Soft Cooked Egg, Toast • French Onion Soup Breaded Liver Parslied Potatoes Escalloped Cauliflower Marinated Asparagus and Pimiento Salad Lemon Chiffon Pie • Cream of Spinach Soup Baked Corned Beef Hash With Tartare Sauce Sliced Tomatoes Fresh Fruit Salad Floating Island Pudding	**3** Fresh Peaches Bacon Curls, Coffee Cake • Fruit Sherbet Cocktail Roast Leg of Lamb Franconia Potatoes Buttered Schnitzel Beans Melon Salad Fresh Coconut Cake • Consommé Deviled Eggs in Cream Sauce Deviled Ham on Toast Vegetable Medley Head Lettuce, 1000 Island Dressing Butterscotch Brownies	**4** Chilled Cantaloupe Soft Cooked Egg, Toast • Beef Rice Soup Veal with Paprika Buttered Noodles Carrots and Peas Combination Salad French Dressing Fresh Peach Sundae • Split Pea Soup Baked Ham Creamed Potatoes Stewed Celery Apricot Dumpling, Cream	**5** Kadota Figs Scrambled Eggs, Muffins • Corn Chowder Baked Beef Loaf Pittsburgh Potatoes Brussels Sprouts Spiced Apple and Cottage Cheese Salad Date Torte, Whipped Cream • Vegetable Soup Welsh Rabbit on Toast Bacon Strips Seasoned Spinach Orange Salad Chocolate Fudge Bars	**6** Orange Juice Bacon, Coffee Cake • Tomato Bisque Escalloped Tuna Fish Parslied Potatoes Buttered Beets Jellied Pineapple, Cheese and Walnut Salad White Cake, Lemon Icing • Cream of Celery Soup Peanut Butter Sandwiches Baked Stuffed Tomato Deviled Egg Salad Fresh Peach Cobbler
7 Fresh Boysenberries Scrambled Eggs, Toast • Fruit Juice Cocktail Creamed Dried Beef Baked Potato Buttered Broccoli Sliced Tomato Salad, 1000 Island Dressing Fresh Apple Pie • Celery Broth Beef Barbecue on Bun Pickles, Coleslaw Angel Food Cake	**8** Orange Juice Bacon, Blueberry Muffins • Consommé Roast Beef Mashed Potatoes, Gravy Buttered Green Beans Head Lettuce, 1000 Island Dressing Ritz Pie, Whipped Cream • Cream of Mushroom Soup Open Faced Bacon, Tomato and Cheese Sandwich Pickles, Potato Chips Fresh Fruit Cup Sugar Cookies	**9** Mandarin Orange Scrambled Eggs, Toast • Apricot Nectar Escalloped Turkey Buttered Peas Baked Potato Stuffed Celery Ripe and Green Olives Fresh Peach Sundae • Cream of Tomato Soup Cold Sliced Roast Beef Escalloped Noodles Jellied Asparagus, Lima Bean and Olive Salad Melon Ball Cocktail With Cookies	**10** Orange Slices Poached Egg, Toast • Chicken Broth Baked Smothered Steak Boiled Potatoes Buttered Zucchini Fresh Raspberries, Cream • Cream of Potato Soup Scrambled Eggs With Minced Ham Green Rice Harvard Beets Apple Dumpling, Cream	**11** Grapefruit Segments French Toast, Sirup • Fruit Juice Cocktail Roast Loin of Pork Mashed Potatoes, Gravy Corn on the Cob Waldorf Salad Lemon Meringue Cake • Chicken Rice Soup Cheese Fondue Buttered Peas Tossed Salad With Julienne Ham and Chicken, French Dressing Custard Pie	**12** Fresh Raspberries Bacon, Toast • Barley Soup Porcupine Meat Balls Candied Sweet Potatoes Buttered Broccoli Ginger Ale Salad, Mayonnaise Date Custard With Whipped Cream • Vegetable Soup Cold Cuts Potato Salad, Olives Hot Bran Muffins, Jam Chilled Watermelon
13 Stewed Fresh Apples Scrambled Eggs, Toast • Baked Salmon Loaf, Cucumber Mayonnaise Parslied Potatoes Broiled Tomato Marinated Green Bean and Onion Salad Fresh Fruit Cup With Orange Ice Topping • Scotch Broth Eggs à la King in Toasted Bread Cases Spiced Apple Asparagus Tip Salad Bing Cherries on Stems	**14** Orange Juice Bacon, Coffee Cake • Melon Ball Cocktail Baked English Lamb Chop Rice Rissoto Minted Carrots Bibb Lettuce, French Dressing Graham Cracker Pie • Mulligatawny Soup Hamburger on a Bun Frozen Peas Pickles Melon Ring Filled With Fruit, Maraschino Cream Dressing	**15** Fresh Raspberries Soft Cooked Egg, Toast • Consommé Fried Chicken, Cream Gravy Mashed Potatoes Escalloped Cauliflower Celery and Pimiento Salad, Special Dressing Fresh Blueberry Deep Dish Pie, Cream • Cream of Potato Soup Tuna Fish Salad, Olives Potato Chips Fruit Gelatin, Cookie	**16** Orange Points Bacon, Hot Rolls • Consommé Schnitzel Veal in Sour Cream Baked Noodles Buttered Carrots and Peas Stuffed Prune Salad Orange Cake, Whipped Cream • Cream of Mushroom Soup Broiled Bologna Cup With Scrambled Eggs Broccoli, Garden Sauce Corn Muffins, Jelly Sliced Peaches, Cream	**17** Grapefruit Juice French Toast, Sirup • Fruit Juice Cocktail Asparagus Tips in Ham Roll, Cheese Sauce Italian Squash Piquant Pineapple Salad, Mayonnaise Chocolate Layer Cake • Cream of Tomato Soup Dixie Sandwich on Bun Assorted Relishes Waldorf Salad Filled Cookie	**18** Kadota Figs Poached Egg, Toast • Celery Broth Fried Chicken Livers Parslied Potatoes Green Beans With Bacon Vegetable Salad Sponge Cake, Slivered Almonds in Apricot Whipped Cream Sauce • Escalloped Shrimp in Shells Celery Hearts Seasoned Spinach Cherry Upside Down Cake
19 Fresh Apricots Soft Cooked Eggs, Toast • Tomato Juice Cocktail Roast Beef Mashed Potato, Gravy Marinated Shoestring Beets and Sliced Egg Salad Fresh Peaches, Cream Sugar Cookies • Oxtail Soup Eggs à la Goldenrod Bacon Curl Buttered Vegetable Medley Pineapple and Cottage Cheese Salad Angel Food Cake	**20** Orange Juice Shirred Eggs, Toast • Cream of Green Pea Soup Fried Perch, Tartare Sauce Paprika Potatoes Corn on the Cob Jellied Grapefruit and Orange Salad Hot Spice Cake with Rum Sauce • Vegetable Soup Baked Macaroni and Cheese Cabbage and Green Pepper Stuffed Tomato Salad Chilled Honey Dew	**21** Sliced Banana, Cream Bacon, Orange Rolls • Chicken Rice Soup French Stew With Vegetables Tossed Green Salad Green Goddess Dressing Toasted Herb French Bread Angel Pie • Scotch Broth Sliced Corned Beef Creamed New Potatoes and Peas Spiced Beets Pineapple Sherbet Coconut Macaroons	**22** Stewed Prunes Poached Egg, Toast • Consommé Broiled Steak Baked Potato Broccoli, Garden Sauce Celery Hearts, Olives, Radishes Peach Melba • Bean Soup Toasted Bacon, Lettuce and Tomato Sandwich Pickles Jellied Banana Salad, Cream Dressing Pound Cake	**23** Ripe Prune Plums French Toast, Sirup • Mushroom Consommé Ham Loaf, Horseradish Candied Sweet Potato Cauliflower au Gratin, Sliced Tomato and Lettuce Lemon Snowflake Pudding • Garden Soup Eggs à la king in Toast Baskets Baked Potato Buttered Vegetable Medley Lettuce Salad, 1000 Island Dressing - Chilled Watermelon	**24** Red Raspberries Poached Egg, Toast • Minestrone Soup Broiled White Fish, Lemon Butter Sauce Parslied Potatoes Carrot Soufflé Chopped Beet Salad Lime Sherbet With Ring of Melon Balls • Hot Vichysoisse Tuna Fish Casserole Buttered Peas Baked Stuffed Tomato Fresh Peach Shortcake With Cream
25 Stewed Prunes Scrambled Eggs, Toast • Beef Barley Soup Salisbury Steak Cornflaked Potatoes Buttered Summer Squash Blushing Pear and Cheeseball Salad Hot Gingercake, Whipped Cream Orange Sauce • Split Pea Soup Toasted Bacon, Lettuce and Tomato Sandwich Pickles Banana-Nut Salad Tapioca Pudding, Cream	**26** Orange Juice Bacon Curls, Toast • Chicken Alphabet Soup Breaded Sweetbreads Au Gratin Potatoes Buttered Beets Cabbage, Pineapple and Marshmallow Salad Baked Caramel Custard Maple Sirup, Chopped Nuts • Cream of Asparagus Soup Chicken and Noodles Broccoli, Brown Butter Fresh Fruit Plate Oatmeal Cookies	**27** Fresh Peaches Poached Egg, Toast • Tomato Celery Soup Breaded Halibut Steak Baked Mashed Potatoes Buttered Brussels Sprouts Jellied Pineapple, Cucumber, Pickle Salad Orange Chiffon Cake, Whipped Cream • Vegetable Soup Shrimp Rarebit in Toasted Bread Shell Buttered Peas Lemon Sherbet Sugar Wafers	**28** Pineapple Cubes Bacon Curls, Waffle • Julienne Soup Boiled Beef Tongue, Raisin Sauce Escalloped Potatoes Buttered Green Beans Head Lettuce, 1000 Island Dressing Bob-Andy Pie • Hamburger on Bun Ketchup, Sliced Pickle Potato Chips Celery, Carrots, Olives Fresh Fruit Cup Filled Cookie	**29** Orange Juice Scrambled Eggs, Bacon • Consommé Roast Turkey Dressing, Gravy Mashed Potato Buttered Turnips Celery, Cranberry Jelly, Olives Raspberry Ripple Ice Cream • Cream of Chicken Soup Sliced Cold Jellied Tongue Hot German Potato Salad Bing Cherries on Stems Date Bars	**30** Chilled Cantaloupe Bacon Curls, Toast • Beef Noodle Soup Mock Chicken Legs Buttered Green Lima Beans Fresh Sliced Tomato Salad, Mayonnaise Banana Layer Cake • Cream of Mushroom Soup Scrambled Eggs Spinach With Buttered Crumbs Apple Dumplings With Cinnamon, Sugar and Cream
31 Orange Juice, Bacon, English Muffins • Fruit Juice Cocktail, Baked English Lamb Chop, Parslied Potatoes, Green Corn Custard, Pear Half With Cream Cheese, Blueberry Roly-Poly, Cream • Bean Soup, Shirred Eggs in Ramekins, Creamed Asparagus, Tomato-Avocado Salad, Spice Cup Cake					

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TURKEY TIME
July 28 - August 8

"NATIONAL VEGETABLE WEEK"
July 28 - Aug. 9

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Consumption UP 115%

Already raised to the rank of one of America's major meats by a dozen years of steadily increasing production and consumption, turkey, this year, will be more popular than ever with hospitals and other institutional users.

REASON: plentiful supplies . . . low prices . . . consumer popularity.

RESULT: turkey consumption (115% increase 1953 over 1935-39 average) fastest-gaining meat on market.

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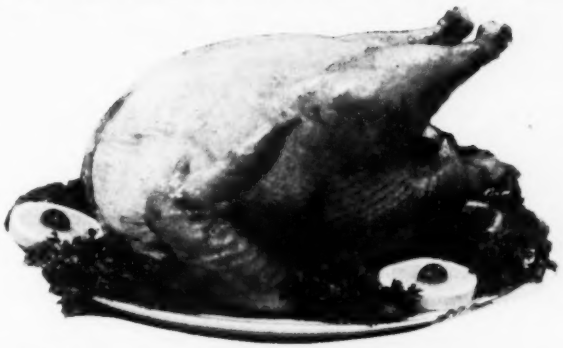

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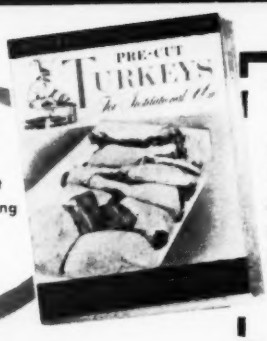

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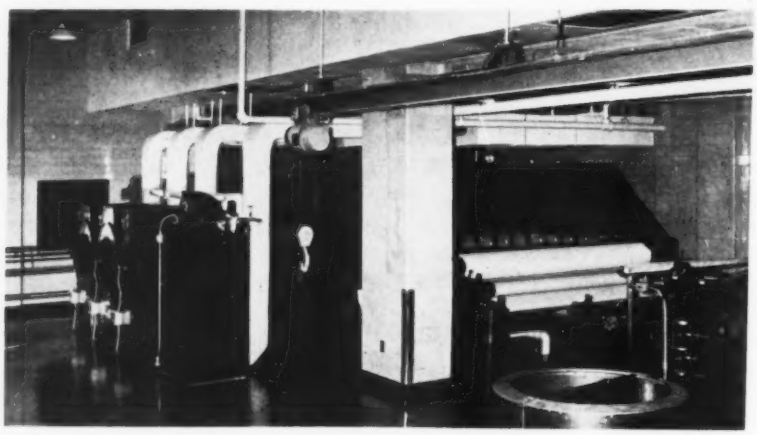
Carney Hospital, Dorchester, Mass.

WHEN and if the new 312 bed Carney Hospital, Boston, which was opened in December 1953, ever adds another 300 beds, the laundry will be able to handle the increased load without breaking stride and without adding any new equipment. Designed by Laundry Manager John F. Knight, in collaboration with the hospital architects, Maginnis and Walsh, Inc., of Boston, and the laundry machinery manufacturers, the department was laid out and equipped with an eye to the potential need. In fact, the hospital's laundry functions like an automobile assembly line. The outstanding feature of the laundry,

(*Continued on Page* 128)

Above: General view of Carney laundry, showing washroom equipment: extractor, washer, soap tank, and rear of unloading washer. Above, right: Here a laundry worker unloads washed clothing from washing machine extractor. Below, left: Workers take clothes from washer to first drier or water extractor. Below, right: Three drying tumblers, one drying cabinet, eight-roll flatwork ironer equipped with folder, a sheet spreader, and, not shown, a tumbler.



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The Elgin is the only softener that gives you the exclusive "Double-Check" design which provides up to 44% more soft water per regeneration than others of equal size utilizing the same type zeolite. Costly zeolite loss is prevented too. With all types of zeolite, and with manual, semi-automatic or fully automatic models from which to choose, there is an Elgin to meet any need — any budget.

How to get 3 to 10 times more soft water from your present water softener

By simply equipping your present water softener with a "double-check" manifold arrangement, its zeolite capacity can be increased as much as 44%. But this, mind you, assumes the same kind of zeolite. If, as in so many cases, your zeolite is the old ineffective type, total replacement of it with Elgin high capacity zeolite may step up your soft water output *three to ten times.*

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or let us have our nearest representative call

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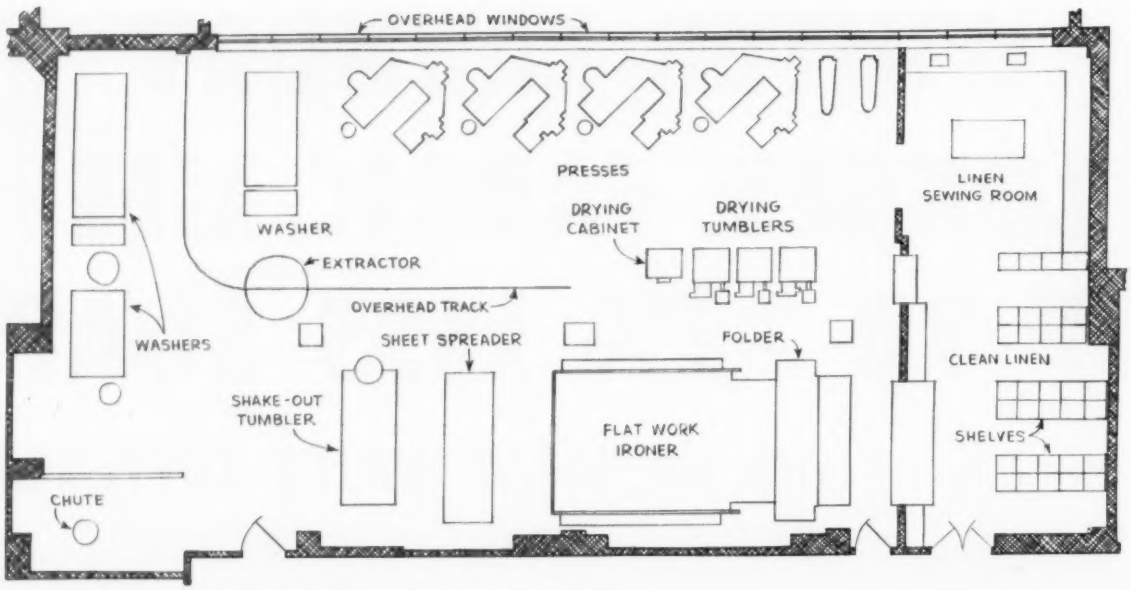

Layout of equipment in new Carney Hospital's laundry department.

Above: A young employe is at work at the spreader. Above, right: At counter of linen room, laundry manager checks the folding operation of the folding machine. The operator's head is just above machine at the right.

Below, left: One of the girls at work at the presser, as the manager inspects the pressed uniforms. Below, right: Two of the four sewing machines in the hospital's linen room. Sewing machine operators have plenty of shelf space.

Linen department supervisor stacks up supply of freshly laundered spreads.

(*Continued From Page* 124)

according to Mr. Knight, is that linen from all eight floors of the hospital is sent directly to the washer on the laundry floor in one straight linen chute that has interjecting outlets from each floor. The particular advantage of the chute is the saving in labor and traffic. Ward aides collect soiled linen from the wards each morning and chute it down to the laundry. Hence, Mr. Knight explained, it is not necessary for him to detach one or two employes from duty in the laundry to collect the linen in hampers, as is done in many institutions. Furthermore, the chute obviates the necessity for loading laundry hampers onto the elevators, with the consequent obstruction of traffic and loss of time.

A staff of 11 employes processes approximately 12,000 pounds of linen per week, on a five-day, 40 hour week. The staff includes linen room employes who are also under Mr. Knight's direction.

The accompanying photographs illustrate the progress of the linen from the time it is placed in the two-compartment washer, through the various processes of extracting, drying, tumbling, folding, and pressing until it is stacked on the linen room shelves.

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Nothing wastes more time in a nurse's day than plumbing fixtures that are too few, too far away, too difficult to operate. The right Crane equipment in the right places can save hours of nursepower every day. Designed with the help of hospital experts, Crane hospital fixtures are specifically made to meet hospital requirements. In height, size, shape, and in types of water controls, each fixture is precisely planned to eliminate lost motion, save time, make work easier. It will pay you to get acquainted with the complete line of Crane hospital plumbing.

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For nurses who have their hands full (and what nurse hasn't?)

Crane knee-operated valves leave *both* hands free for those countless daily tasks at sinks and lavatories.

Fitted with a combination hot and cold water control, this valve responds to the slightest touch of the knee . . . providing water that's all hot, all cold, or mixed exactly as wanted.

Promotes sanitation, too. No dirt or germs pass from one pair of hands to another.

For complete information about this and other Crane specialized hospital equipment, see your Crane Hospital Catalog or call your Crane Branch, Crane Wholesaler or Plumbing Contractor.

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Six Simple Steps to a Learning Program

MADGE H. SIDNEY
Executive Housekeeper
Evanston Hospital, Evanston, Ill.

A FEW years ago I had a dream of a perfect classroom, set up with all necessary furniture and equipment, a variety of floor coverings, a trained assistant as instructor with a well planned curriculum for anxious-to-be-taught employes. My plans were elaborate but my dreams were idle. There never seemed to be enough space available, enough time for teaching, or enough interest in a training program for housekeeping employes.

Then I attended the 1953 Upper Midwest Hospital Conference and for the first time heard about "Dynamic Learning Technic." What an inspiration! Phrases kept going over and over in my mind.

"Unless administrators want learning to take place—it will not."

"Learning is the basis for all adult activity."

"Learning is fundamentally an emotional activity, not an intellectual activity."

"Attitudes change through conference and supervisory training."

"Learning takes place only when the individual wants to learn."

"Learning" is a much stronger word than "teaching." I was one step toward my goal. I really wanted learning to take place. Now, if I could change the attitudes of my employes, if I could instill in them the desire to learn, the rest would be easy. However, in order to change attitudes I had to know their present attitudes. I had to find out as much as I could about my employes.

So I adopted a merit rating system which can best be explained by an excerpt from a letter written to the American Hospital Association Correspondence Club (made up of graduates of the Michigan State short course in housekeeping) by my assistant:

"Realizing the need for a more accurate gauge of less obvious results it was decided to adopt a merit rating system with which we could sift out the strength and weakness of each employe.

"The merit rating form covers seven specific points: (1) attendance, (2) appearance, (3) personal habits, (4) relationship, (5) work habits, (6) work interest, and (7) work output.

"These main groupings were broken down into factors helpful in grading the employe. For instance, under (1) attendance, we placed (a) lack of absenteeism, (b) utilization of work and time, (c) promptness. Under (2) appearance, we placed (a) personal cleanliness, and (b) neatness. In like manner the remaining headings were broken down into various subdivisions.

"The code used in rating each point was: A (4) for Superior, B (3) Good, C (2) Fair, D, (O) Unsatisfactory. The total points add up to a possible 100.

"A second rating of all employes is planned for six months from the first rating, and it is our belief a marked improvement will be indicated.

"The merit rating is done by the supervisor directly responsible for the work of the employe. I, as assistant housekeeper, check over each form and indicate changes in the rating if I have a difference of opinion. The executive housekeeper discusses the results with us at our weekly staff meeting and corrective procedures are adopted if needed.

"There are a number of benefits to be found in the merit rating system. The employe is stimulated to increased efforts and benefited by additional training. The supervisor, to give a fair score, must study her employe thoroughly and at the same time eliminate personal prejudices. I, as head of the learning program, can plan special classes to eliminate weaknesses plainly revealed in the merit rating forms. The executive housekeeper has at hand a chart indicating the pulse of her department."

The second step toward my goal was completed.

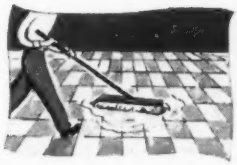
I could skip the third step because I already had an instructor with a degree in home economics, a short course in hospital housekeeping at Michigan State, and two years' experience in hospital housekeeping. What more could one ask? An apt scholar in the school of housekeeping, well prepared to present problems for "learning" is my assistant, Julie Hankwitz, writer of the foregoing letter.

CALLED "HOT ROOM"

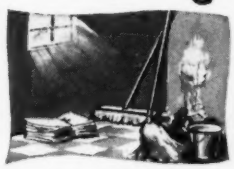
Where there's a will there's a way. We found a classroom. It is still called the "Hot Room" because it was just that—"a small useless basement room, too hot for man or beast"—until our janitor removed some pipes, and redirected the heat to unknown areas. Then we added a coat of paint, some folding chairs, a desk, lamp, blackboard, and *voila!* Step No. 4 was taken —a classroom (with a window).

We set up class schedules almost before we had our program planned, and realizing that "learning" could take place more effectively in small

Why Risk Fire with an Oily Dressing?



Oily dressings with even a high flash point constitute a constant fire hazard in daily use.



Mops and rags saturated with such solutions when stored often cause spontaneous combustion . . .

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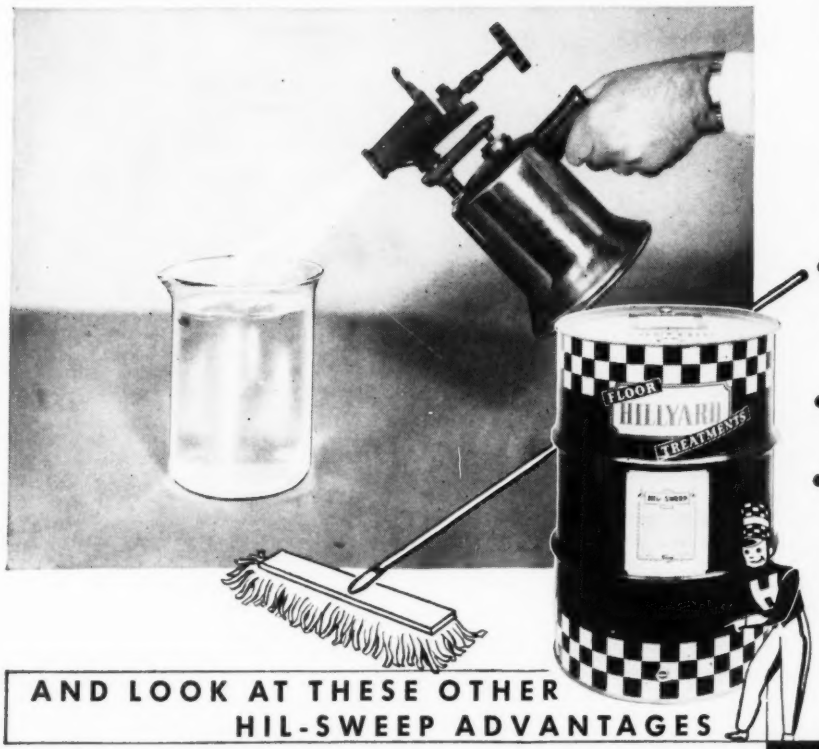

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- You can spray it or sprinkle it on brush, mop or dust cloth.
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- Won't load mop like other floor dressings. After using simply shake out brush or cloth and it's ready to use again. Saves on laundry and dry cleaning bills.
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groups, we set our schedules accordingly and planned for each employe to attend one half-hour session each week. We kept the sessions short and interesting. The supervisor attended as well as the maids and porters. The complete course was covered, then there was a lapse of one month, and the course was repeated for those who needed additional help, those who had missed classes, and for all new employes who had had only a briefing up to that point.

This fifth step, scheduling about 100 employes without interfering with hospital routine, was quite a task; it took intestinal fortitude.

The sixth and last step, the "Learning Program" is outlined herewith:

FOUR LEARNING OBJECTIVES

1. Development of effective attitudes toward:
   a. Job
      (1) Rules
   b. Hospital
      (1) Policy
      (2) Benefits
   c. Supervisors
2. Passing on of general and specific knowledge about:
   a. Hospitals in general
   b. The hospital
   c. The particular department
3. Development of specific job skills:
   a. On the job
4. Nurturing of specific and desirable work habits:
   a. Through training program
   b. Through daily supervision
   c. Important elements
      (1) Safety
      (2) Quality
      (3) Precision
      (4) Neatness
      (5) Care in keeping material clean
      (6) Care of work place
      (7) Care of equipment
      (8) Tardiness
      (9) Absenteeism
      (10) Over-all efficiency

LEARNING PROGRAM

Orientation

Location and use of time clock:
1. Time clock room
2. Operation of time clock
3. Rules to remember
4. Exits for employes
5. Permits for packages

Uniforms:
1. Obtaining
2. Care

Location of locker rooms:
1. Assignment
2. Cleaning
3. Rules and regulations

Location of cafeteria:
1. Rules

Induction

Fire instructions:
1. Introduction
   (a) Prevent fires—watch for hazards
   (b) Report fire hazards to housekeeping office at once
   (c) Know location of fire equipment and exits in your section
   (d) Avoid panic and confusion in case of fire
2. Fire fighting team
   (a) Members
   (b) In case of fire

Appearance:
1. Importance of personal cleanliness
2. Clothes in relation to good posture
3. Regulations on jewelry, perfume, etc.

Conduct

Attitudes:
1. Toward job and hospital
2. Toward patients and visitors
3. Toward employes

Health and Safety:
1. Of self
2. Of others

Supplies:
1. Kinds
2. Use
3. Demonstrations

Equipment:
1. Types
2. Use
3. Demonstrations

Floors:
1. Types
2. Care
3. Demonstrations

Beds:
1. Types
2. Adjustment
3. Bed making

designed
for today's advanced standards . . .

The Mount Sinai Hospital in Toronto uses warm colors and inviting rooms to eliminate cold, clinical "hospital atmosphere."

KAPLAN & SPRACHMAN — Govan, Ferguson, Lindsey,, Kaminker, Maw, Langley, Keenleyside, Associate Architects. J. J. Golub, M. D., Hospital Consultant.

TORONTO'S NEW MT. SINAI HOSPITAL
a large user of Vollrath Stainless Steel Hospital Ware

THE new Mount Sinai Hospital in Toronto, Ontario—with over 400 beds for patients — incorporates many innovations in construction, materials and equipment . . . joining ideas of the future with advancements of today.

Modern Hospitals like Mount Sinai demand durability and functional good looks from all their equipment. This is particularly true in the selection of clinical utensils.

That's why Mount Sinai uses long-lasting Vollrath stainless steel ware. This heavy-gauge stainless steel equipment is sturdily built to stand up under the rugged wear of daily use. Quality materials and fabrication give you long range economy and minimum replacement. What's more, seamless, crevice-free construction makes Vollrath Ware easy-to-clean for everlasting brightness . . . certain to conform to rigid sanitary standards.

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Special instructions:

1. Medical sections
2. Surgical sections
3. Maternity sections
4. Contagious sections
5. Psychiatric sections

Review and Discussions

TOPICS FOR NEW PERSONNEL

Orientation and Fire Instructions

Safety Measures

Demonstrations:

1. Vacuum cleaners
2. Buffers
3. Supplies and uses
4. Mops
5. Brooms and brushes
6. Toilets and urinals
7. Beds:
   (a) Adjustments
   (b) Bed making

There you have the six steps to our learning program. They are simple but effective. We have established a program for learning and, as attitudes change, the desire to learn should grow; then our program should expand, and maybe some day when the program proves its worth and the hospital sees the benefits derived from it we might have that model classroom. My dream might come true!

N.E.H.A. Admits Men; Restores Assistants

CHICAGO.—Somewhat to its own surprise, the National Executive Housekeepers Association, meeting at the Drake Hotel here, June 2 to 5, opened its membership to men housekeepers by the simple process of excising the restrictive word "women" in the section of the by-laws covering membership. Thus, the N.E.H.A. took official cognizance of the fact that men housekeepers are here to stay and that their entrance into the field cannot be deterred by the mere act of barring them from membership in the association.

Some few recalcitrants, led by the New York chapter which has steadfastly contended that a man's place is anywhere but in housekeeping, dragged their heels, but the more realistic majority prevailed in the voting.

Skillfully piloted by Parliamentarian Grace Brigham, who, with the genius of the born teacher, managed to clarify even the complexities of parliamentary procedure, the delegates successfully navigated another rocky shoal, which at one time had threatened to founder the association. This was the question of assistant housekeepers. At the 1950 congress held in Washington, D.C., assistant housekeepers were summarily ejected from membership after a tumultuous debate. At the 1954 session, the delegates quietly and with almost no discussion voted to include as associate members "executive assistant housekeepers of hotels of 400 rooms or more, and of hospitals of 300 beds or more who have had two years' experience. They must be recommended for membership by their executive housekeeper, who must be an active member in good standing."

Emphasis at this meeting was on various aspects of education for executive housekeepers. The delegates evinced particular interest in correspondence courses for hotel employes being established by Mississippi State College under hotel association sponsorship, as described by Paul Valentine.

Mrs. Catherine Peifer, executive housekeeper of the Drake Hotel in Chicago, retired as president of the association. She was succeeded by Rosalie Soper, Brown Palace Hotel, Denver. Other new officers elected are: vice president, Frana Hayes Bayer, Henry Hudson Hotel, New York City; secretary, Beulah Taylor, Madison Hotel, Atlantic City, N.J., and treasurer, Delia Tellin, Pittsburgh.

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ROVING REPORTER

(*Continued From Page* 12)

bourne, it has a modern building well equipped for teaching purposes and an excellent full-time faculty. Student nurses from affiliated hospitals come to this central school once a year for a block of time and attend lectures, demonstrations, seminars and study without the distraction of ward work. Their practical training is received in the wards of affiliated hospitals. The school is supported financially by the state.

The training of dietitians in Australia has assumed a good level and most hospitals have a well organized dietary department. As in our own country, food service and its administration in hospitals takes up a large percentage of the budget. Some of the larger hospitals lean toward the food manager plan, or caterer. In most hospitals, however, the dietitian is in full control of the food service and has an important status in the hospital organization. The success of the food manager plan depends on the general knowledge the manager has of food values and his cooperation with the dietitian.

There has been a great impetus to the training of medical record librarians since the visit to Australia of Edna K. Huffman of Chicago about three years ago. Better organized record departments are apparent and the quality of medical records is good, except those on private patients which, in most instances, are lacking.

Throughout Australia there was general interest manifested in the development of uniform standards for hospitals. On each occasion when the subject was discussed, there was an expressed desire to institute hospital standardization or accreditation in Australia, provided the necessary finances and sponsorship are made available.

The Australian Institute for Hospital Administrators has been established for eight years. Admission is based on knowledge, experience and examination. The present membership embraces 64 fellows, 42 associates, 265 students, and one honorary fellow.

The institute has an extension course for hospital administrators throughout Australia. Texts in the form of loose-leaf tutorial booklets, covering the entire field of hospital administration, are sent to the registrants in the course of study. Examinations are conducted and a careful evaluation is made of the student's knowledge of hospital administration. There is no time limit on completion of the course, but the student must cover each of four parts and pass an examination on the content. When he has accomplished this, he is certified as a member of the institute and later can proceed to fellowship by passing an examination and submitting a thesis.

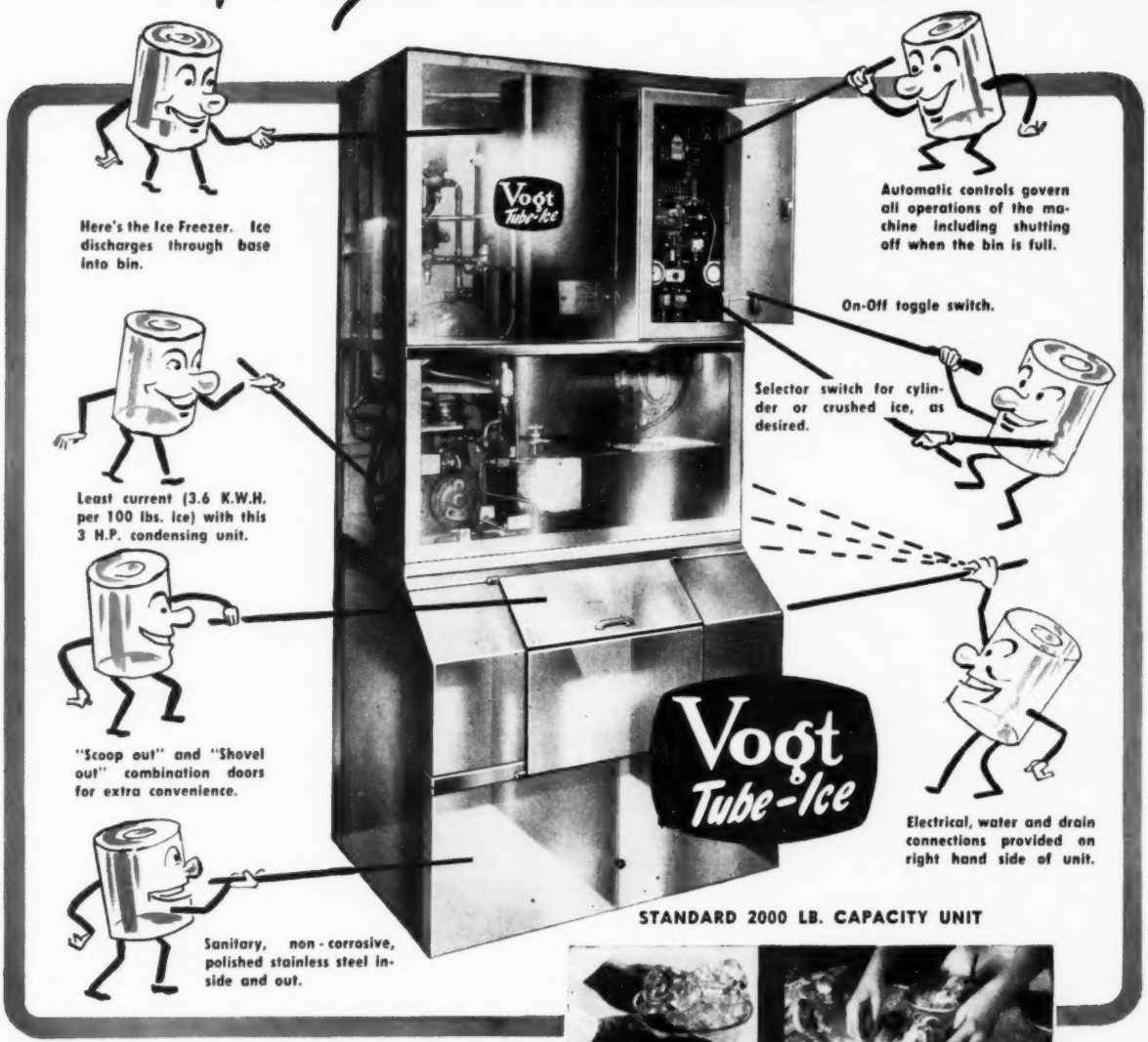
If he is a member, he is entitled to put after his name the letters M.I.H.A. (Member of Institute of Hospital Administrators) and, if he is a fellow, the letters F.I.H.A.

It is believed the course could be improved by having the students come to a central place for 10 days or two weeks annually for the review of the lessons sent to them during the year.

In addition to the institute, there is need for a university course in hospital administration on the graduate level. I found considerable interest in establishing such a course in the School of Public Health at the University of Sydney.

After a most memorable visit to Australia we left on December 3 and arrived home last December 10.

Here's inside information on the finest Ice making unit ever made



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Methods Engineering Is Organized Common Sense

(*Continued From Page* 87)

magazines but also we must have the cooperation of the doctor, so that he will give that information to the patient.

MR. JONES: That's an interesting point. You can't get anywhere with any kind of program in a hospital if you don't have the staff doctors behind you. I'd like to hear something from Dr. Carter about his experience with the medical profession in his hospital when these methods studies were started.

DR. CARTER: Well I can't say that there was much, if any, reaction when we started these studies, because we started them in departments with which doctors have little contact.

MR. JONES: Dr. Sutton, from your standpoint as a physician, do you think it is possible to get a medical staff squarely behind a program like the one they are carrying out here at St. Luke's Hospital?

DR. SUTTON: Yes, I think it is. We have to acquaint the doctors with the fact that they do have a great deal to do with hospital costs. It's amazing, but most doctors don't realize that. They criticize the costs, not understanding that they themselves contribute greatly to them.

MR. CLARK: Hasn't that a little bit to do with the fact that we have allowed them to go along thinking that way? We should have changed their thinking along that line some time ago. Instead we have to make an intensive effort now, don't we?

DR. SUTTON: Yes, I think we have. Until the physician understands that he does have a great deal to do with hospital costs we can't get much cooperation from him.

SOME FEAR OF DOCTORS

MR. SHOOS: Our experience here at St. Luke's certainly demonstrates that the doctors are the individuals who are ordering the procedures which the hospital organization has to produce, and it takes skill, time and people to do that job.

MR. JONES: Too many administrators are afraid to go to the medical staff as an organized group, and to the individual doctors, and ask for help. We have to break down that fear on the part of administrators and get them to see that the organized staff can do the job.

DR. CARTER: We've got to the point here where some of the staff members are coming to me, wanting to know how they can help on the economics of this thing, and I've been thinking about the possibility of organizing a committee in the field of economics which would function somewhat as a tissue committee functions. However, you have to be awfully careful about labeling it "hospital economics," or anything of that sort, because then we begin to invite intrusion into everything that has to do with the economics of hospital organization.

ECONOMICS IN MEDICAL SCHOOLS?

DR. SUTTON: Yes, but maybe we should begin to teach a little economics in the medical schools so that doctors will have a little background to build on.

MR. JONES: As a physician, Dr. Carter, don't you think there is value in having the methods engineering department study all the routines and procedures of admitting, diagnosis and discharge of patients so we can get them in and out of the hospital faster than we are now doing it?

DR. CARTER: Oh yes. Our medical staff has worked right along with Mr. Frederick in drawing up plans for the operating room, for example, and in the matter of organizing our emergency department. In fact, we have had Mr. Frederick in on most of the changes that we have made around here.

MR. SHOOS: We like to have our methods department consider any project we undertake, whether it's new or a revision of the old. I would say that the medical staff is very much interested and is becoming aware of the part it plays in this whole problem of hospital costs.

(To be concluded in a later issue)

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How they put the heat on

DOCTOR MOUSEL'S SALARY

(*Continued From Page 52*)

Dr. Mousel stated he was charging private fees for all anesthesia rendered personally by him.

In a brief filed with the Judicial Council in Dr. Mousel's behalf, Dr. Charles MacMahon, then chief of staff at Swedish Hospital, contended the membership of the society was largely ignorant of the facts. "Realizing that the controversy was not resolved," Dr. MacMahon said, "I requested that the facts of the case be presented to the society by its responsible officers so that the membership would not be voting in ignorance and on the basis of the grossly inaccurate rumors that were flying through the corridors of other hospitals in this city. It was the attitude of the president and chairman of the membership committee that they had no intention and no right to present the pros and cons of this subject to the membership. . . . In short, then, for the second time, the society voted unfavorably on Dr. Mousel without having ever been accurately and properly informed as to the facts of the case."

ANOTHER ELECTION SUGGESTED

Obviously believing there was some justice in this argument, the Judicial Council suggested that another election should be held. This time, plainly, both sides made some effort to "get out the vote." When Dr. Mousel's third application was voted on at the February 1954 meeting of the society, the count was 196 for and 162 against—representing a gain in strength for his supporters, but, again, far short of the necessary four-fifths majority. Again, Dr. Mousel appealed to the Judicial Council to "take further action to implement my admittance to the King County Medical Society." On March 17, 1954, the Judicial Council wrote him, referring to its ruling of last December: "It does not seem feasible or possible to remove from the local society the right to judge as to who shall be admitted to membership," this said. "The attempt to force a local society to accept as a member one who has been rejected by a fair vote of the society can result only in disaster to the organization. On the other hand, local prejudice or personal animosity or spite may . . . by keeping a man out of his local society, unjustly debar him from membership in our organization."

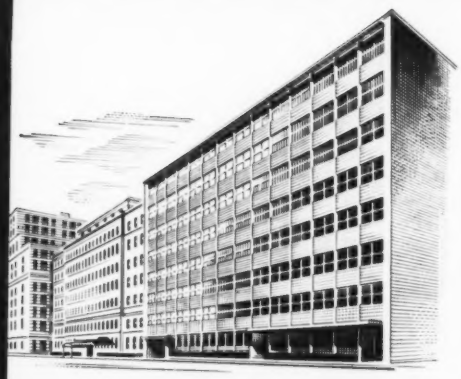
LOCAL PREJUDICE INFERRED

Inferentially, at least, the council's letter of March 17 acknowledged that "local prejudice or personal animosity or spite" may have been at work against Dr. Mousel.

"The opinion of the Council . . . was that fair play to you, the King County Medical Society, and the American Medical Association required that your application for membership be again presented to the membership of the King County Medical Society for vote after certain specified information was made available to the membership," this ruling stated. "The Judicial Council has not been advised that the information referred to in its letter of December 3 was not made available to the membership of the King County Medical Society, or that members of that society acted other than according to their own convictions when your application for membership was again voted upon. It is the consensus of the Judicial Council that no further action can properly be taken by it to implement your admittance to the King County Medical Society."

While there is still some dispute about whether or not full information on Dr. Mousel's method of practice was available to the membership on the occasion of the third vote, it is Dr. Ramsay's opinion that this wouldn't have made any difference in the result—a reasonable view, considering all that had happened. While Dr. Ramsay describes himself as being "neutral" toward Dr. Mousel personally and has, in fact, voted in favor of his application, he feels that the votes have represented the honest opinions of the membership, acknowledging that the feeling reflected is directed as much against the hospital as against Dr. Mousel.

"Hospital charges are too high anyway," Dr. Ramsay said recently, in-



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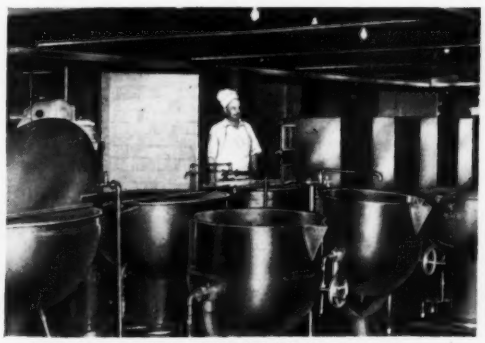

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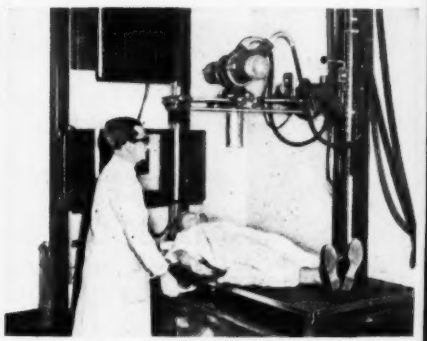

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Dr. Mousel's Salary

dulging in a little of this feeling himself. "If the full truth were known," he added darkly, "public opinion would be on the side of the doctor and against the hospital." In addition to the exploitation which he is convinced exists in the case of Dr. Mousel, in view of the refusal to disclose the facts about his salary, Dr. Ramsay believes the hospital is "practicing medicine" in the operation of its tumor clinic, which accepts patients directly and refers them to surgeons of the hospital's choosing. "I considered taking this up with the grievance committee of the society," Dr. Ramsay told a reporter, "but I decided against it, because we have enough trouble already. I have to live and practice here, and I don't want any more fights than we already have on our hands."

NO LACK OF DEFENDANTS

Dr. Ramsay is not personally named as a defendant in the suit that is now pending—a circumstance that removes him, at least technically, from the fight. However, there is no lack of defendants. In addition to Associated Anesthesiologists, the State Society of Anesthesiologists, the King County Medical Society, and various officers and members of these groups, the suit also joins the King County Medical Service Bureau, a prepayment plan; the Pacific Northwest Society of Pathologists; the Washington State Society of Radiologists; the Pacific Northwest Radiological Society; the King County Medical Service Corporation, and the presidents of these various organizations. "The membership of each of such organizations is so numerous as to make it impracticable to join individual members by name," the complaint states. "Each of the respective physicians whose name appears after the name of each association . . . is a member thereof and is joined individually and as representative of all other members thereof."

As a result of the defendants' conspiratorial acts as charged in the complaint, the plaintiff has "regularly suffered" the following grievances, it is alleged: "His professional and personal reputation and character have been damaged; this damage has been very extensive but it is of such a nature as not to be susceptible to definite calculation in monetary terms. The plaintiff has been subjected to professional and social ostracism. He has been subjected regularly to humiliation and mental suffering and embarrassment among physicians, plaintiff's friends, acquaintances, patients and members of the public. He has been seriously hindered in the pursuit of his profession. His employment at the Swedish Hospital has been placed in jeopardy. If plaintiff loses this position, he has been placed in serious danger of being unable to secure employment at any other hospital in Seattle or anywhere else in the United States.

"Plaintiff has exhausted his remedies by appeal or otherwise within the American Medical Association and defendant organizations.

"Unless the relief is granted which is prayed for herein, defendants will continue their conspiracy and unlawful course of conduct directed against the plaintiff. . . . In addition, defendants will cause plaintiff's expulsion from the American Medical Association and by this and other means will strengthen their conspiracy and accentuate their unlawful course of conduct directed against the plaintiff."

In addition to asking for injunctions restraining the defendants from continuing their conspiracy and refusing to admit him to membership in the King County Medical Society and Washington State Society of Anesthesiologists, Dr. Mousel requests the court to order the defendants "to publish a suitable statement that it is no longer the policy of any of them to carry on such combination or conspiracy or to do any of the acts in furtherance thereof." The complaint also asks for "plaintiff's costs and disbursements herein, and for such further relief as may seem just to this court."

MAY NOT BE IN VAIN

However, Dr. Mousel is not seeking, nor does he expect to get, financial relief. "Actually, I want only what the other anesthesiologists here, and doctors everywhere, are seeking," he told an acquaintance recently, "—that is, freedom to practice my profession ethically and lawfully."

As both sides carry out their pretrial maneuvers, anesthesiologists, other specialists, and doctors and hospital administrators all over the country will be looking on, hoping that the issues involved in the question of "corporate practice by hospitals" may come at last into focus in Seattle. If this should happen, Dr. Mousel's reluctant martyrdom will not have been in vain, no matter what the court decides.

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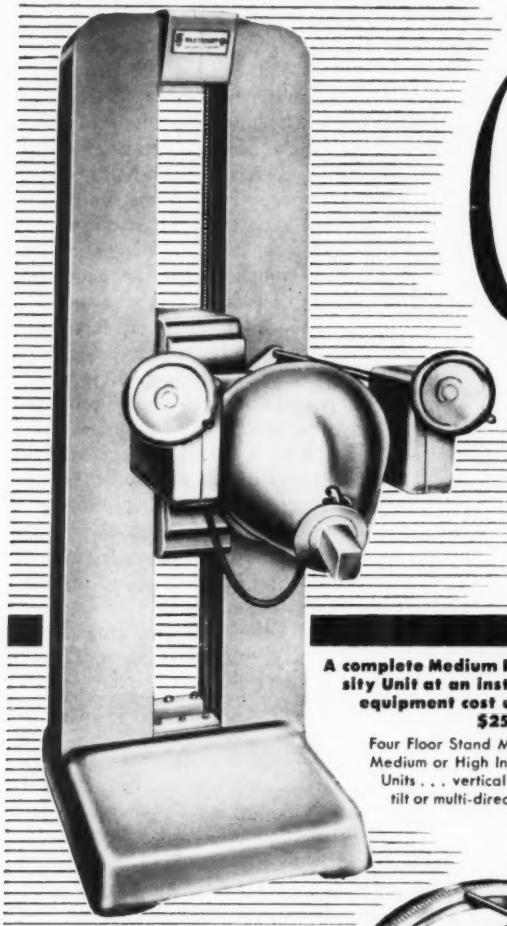

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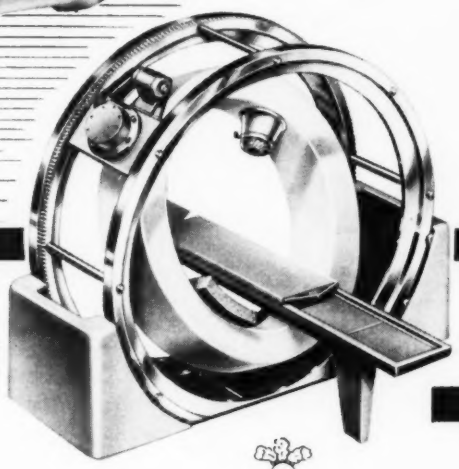

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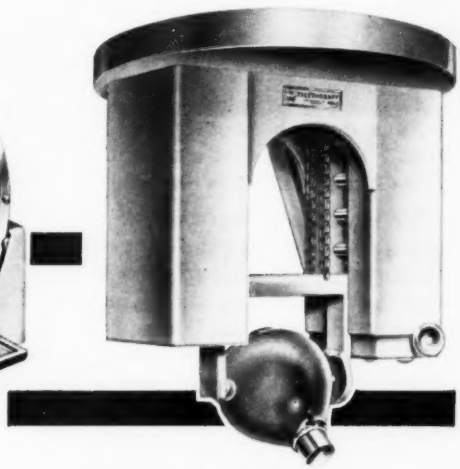

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Catholic Association Meets

(*Continued From Page 77*)

fax Infirmary, Halifax, Nova Scotia, presented the annual report of the executive board. Outstanding among the year's accomplishments, Sister Gerard said, were a program of regional conferences for higher superiors in Catholic hospitals. More than 75 per cent of the Mothers General and Provincial in charge of Catholic hospital programs took part in the conferences, it was reported. Other outstanding activities of the executive board included completion of the new headquarters building of the association, an expanded program of services to member hospitals, and development of organized Catholic hospital groups in 80 per cent of the states and provinces.

Reporting for the headquarters staff, Rev. John J. Flanagan, S.J., executive director of the association, emphasized the interest of Catholic hospitals in medical staff organization, medical-administrative relationships, and accreditation. He emphasized the need for association hospitals to be "thoroughly Catholic"—with emphasis on the spirit of charity as well as on professional excellence.

The Very Rev. Msgr. R. A. Maher of Toledo, Ohio, was named president-elect of the association at the annual business meeting. As first vice president of the association during the preceding year, Msgr. Maher had taken over the duties of the presidency shortly before the convention, following the unexpected death of Rev. Francis P. Lively of Brooklyn, N.Y.

The Very Rev. Msgr. Edmund J. Goebel of Milwaukee, president of the association for the coming year, took office during the meeting.

Other officers named by the association were: first vice president, Rt. Rev. Msgr. J. L. Gatton of Springfield, Ill.; second vice president, Rt. Rev. Msgr. Joseph B. Toomey of Syracuse, N.Y.; secretary, Mother Bernard Mary of Hartford, Conn., and treasurer, Sister Agnes of the Sacred Heart, Seattle.

The convention closed with a Holy Hour conducted by the Very Rev. Ignatius Smith, dean of the school of philosophy of the Catholic University of America at Washington, D.C. The Holy Hour commemorated the Marian Year, marked by special devotions to the Virgin Mary, to whom were directed prayers and petitions to bless hospitals with more vocations, or calls to Christian service.

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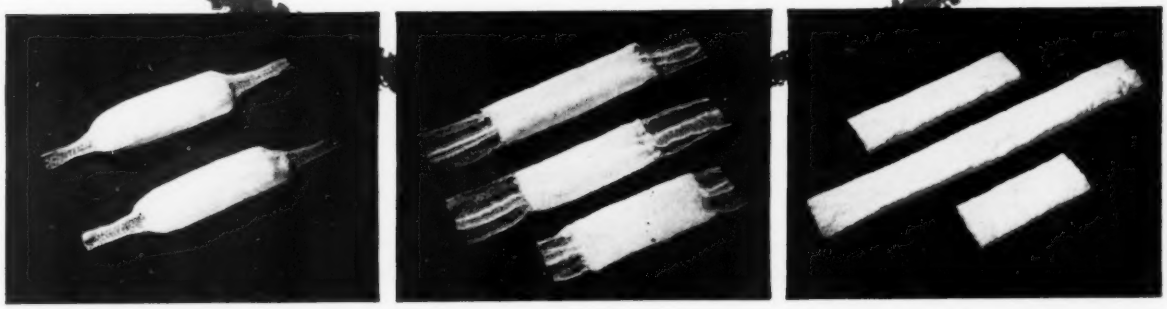

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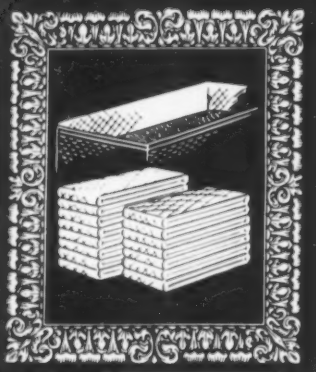

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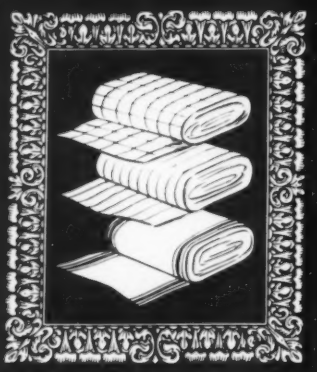

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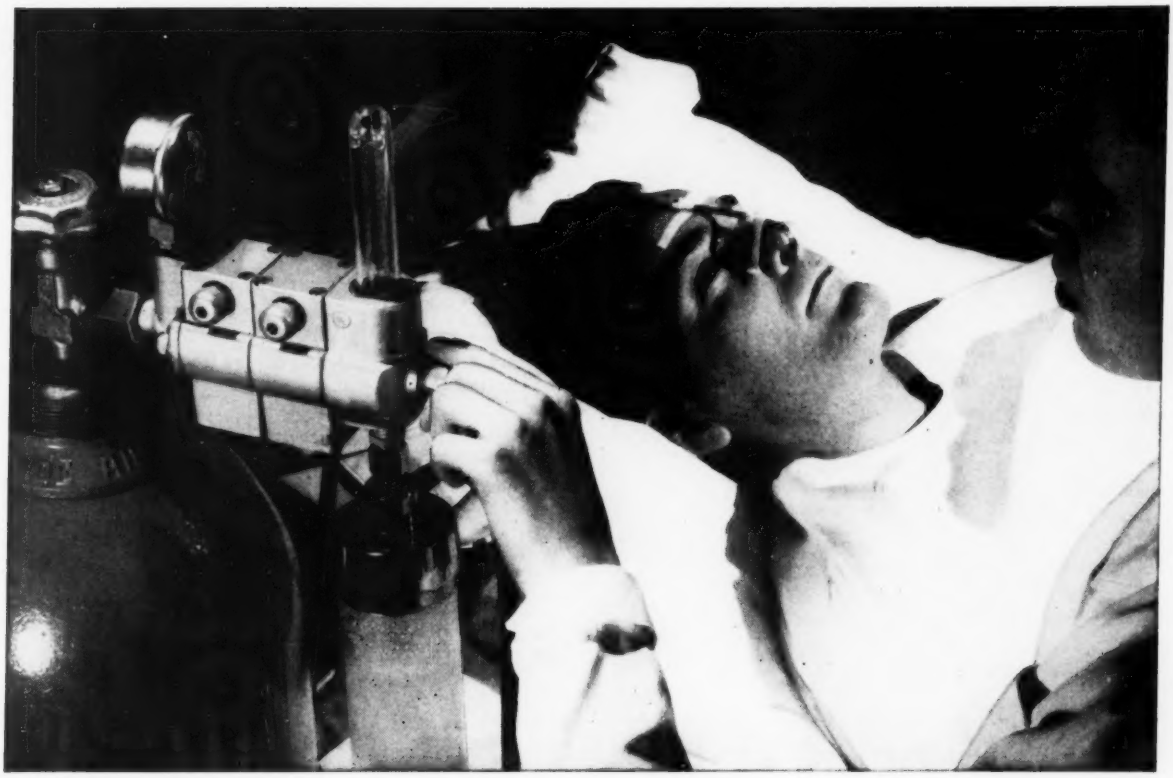

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NEWS DIGEST

Middle Atlantic, Tennessee and Texas Conventions . . . Red Cross Quits New York Blood Bank Group . . . Argue Quality of Nursing Care . . . Surgeon Concedes Hospital's Right of Dismissal . . . Medics Fight Group Practice

Surgeon Concedes Hospital's Right to Dismiss Him

INDIANAPOLIS. — St. Vincent's Hospital here was within its rights last year when it discharged three members of the medical staff, it was acknowledged here last month by the attorney for Dr. Karl R. Ruddell, one of the ousted doctors. The attorney made the concession at a pretrial hearing in Dr. Ruddell's circuit court suit against the hospital and its administrator, Sister Lydia.

Dr. Ruddell is suing for slander and "vindication," charging that his reputation was damaged by remarks attributed to Sister Lydia following the episode last April.

Dr. Ruddell, a surgeon, and two other members of the St. Vincent's staff were discharged following examination of hospital records in a medical audit early in 1953. The case was reported in the Indianapolis press when the doctors protested this action by the hospital.

In the pretrial hearing last month, Frank M. McHale, Dr. Ruddell's attorney, acknowledged that a private hospital has the right to discharge members but contended his client's "nationwide reputation" as a surgeon had been defamed by the publicity.

Red Cross Leaves N.Y. Blood Bank Group

NEW YORK.—Announcement of a new Blood Assurance Program by the Blood Banks Association of New York State here last month precipitated severance of relations between the association and the American Red Cross and a sharp exchange of charges between Dr. William M. Markel, administrator of the New York Regional Blood Program of the Red Cross, and Dr. J. Stanley Kenney, president of the association and past president of the New York State Medical Society, whose

(*Continued on Page* 162)

Tennessee Delegates Take Part in Buzz Session, Hoe-Down, Small Hospital Forum on Patient Care

GATLINBURG, TENN.—Delegates at the Tennessee Hospital Association's annual convention held at this resort May 20 to 22 saw R. G. Ramsay Jr., administrator of the Gartly-Ramsay Hospital, Memphis, take office as president, succeeding Harold Prather, administrator of East Tennessee Baptist Hospital, Knoxville.

Other officers elected were: president-elect, Frank S. Groner, Baptist Memorial Hospital, Memphis; first vice president, John H. Tallmadge, Fort Sanders Presbyterian Hospital, Knoxville; second vice president, J. F. Meisamer, Uplands Cumberland Mountain Sanatorium, Pleasant Hill, and treasurer, James M. Ferguson, East Tennessee Tuberculosis Hospital, Knoxville.

Trustees elected were Ernest L. Bliss, Jackson; Frank Magoffin, Memphis; M. Gaylord Hubbard, Nashville, and Charles Holmes, Memphis. James M. Crews, administrator of Methodist Hospital, Memphis, was elected for a two-year term to the A.H.A. house of delegates. Mr. Hubbard, head of the Nashville General Hospital, will serve as alternate delegate. The board of trustees reappointed Henry H. Miller of Nashville as executive director of the state association.

Meeting concurrently with the Tennessee Hospital Association were the Tennessee Society of Hospital Pharmacists and the Tennessee Association of Medical Record Librarians. Chattanooga was selected as the city for the 1955 annual meeting.

A registration of 231 was the highest recorded; it represented 22 large hospitals and 33 smaller ones.

(*Continued on Page* 152)

Behind Dr. MacEachern, "best dressed male" at hoe-down, are Dr. Kenneth B. Babcock, Everett W. Jones, Dr. Arthur N. Springall, Gordon E. Friesen, Harold Prather, and R. G. Ramsay Jr.

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AMONG THIS YEAR'S GRADUATES OF PROGRAMS IN HOSPITAL ADMINISTRATION

NORTHWESTERN UNIVERSITY.
Front Row: Maudie Horne, John Strawbridge, Mary Sullivan, Jack Docktor, Maura Giménez-Merlo, Dr. Sabih Djazzar, Joseph Rogers, Nolan Lackey. Second Row: Artee Hammond, Forrest Neumann, Kayo Dokken, Dr. Kobayashi, Robert James, Charles Banish, J. R. Frye, Samuel Johnson, Jessie Bartlett, Third Row: Welch England, Andrew Saphiloff, William Hamrick, Donald Pound, Masaichi Tasaka, Albert Donnel, Gerald Woods. Fourth Row: Robert Gleeson, John Milton, Robert Moore, Ernest Williams, James Henry, Alan Campbell, Raymond Tate, Talmage Smith. Fifth Row: Pasqual Capitanelli, John Wisda, Newell France. Sixth Row: Brady Fowler, Daniel Kehoe, George Allen, Earl Skogman, Thomas McCarthy. Prizewinners were: Harold Wayne Maysent, Malcolm T. MacEachern Award; Malcolm Dean MacCoun, Mary H. McGaw Award; Earl C. Mechtensimer, Fred Geck Award; Leon Felson and Woodrow Wilson Fanning, Surgical Trade Association Award. (See also page 160.)

UNIVERSITY OF CHICAGO. Front Row: Sophie Zimmermann (coordinator), Jack A. White, Edward W. Weimer, Jack H. Houtz, Le Roy Williams. Second Row: Richard L. Johnson (associate director), William L. Loving, David A. Johnson, Dr. Edwin F. Rosario, Edward S. Glavis, Erwin Rembolt. Third Row: Ray E. Brown (director), Stuart C. Mount, Marion Jane Holl, Ernest C. Gray Jr., L. Edward Naegeli. (See also page 160.)

UNIVERSITY OF TORONTO. Back Row: Edward G. Hertfelder Jr., Bernard McCarthy, Gdalyah Ben-Zion Rosenfeld, Ronald J. C. McQueen. Second Row: Peter Swerhone, Norman Dearlove, Cecil Kennedy, Gerald Turner. Third Row: Donald Robertson, Sister Mary Fintan, Sister M. Janet, John Partlo. Front Row: (Staff) D. M. MacIntyre, Dr. G. Harvey Agnew, Eugenia M. Stuart, Dr. A. S. Swanson. (See also page 160.)

ST. LOUIS UNIVERSITY. Back Row: Harold W. Steadham, Ronald S. Simon, Fred J. Stonage, Paul R. Wozniak, Joseph B. Mackey, Robert M. Hofmann, Edward A. Behrman, John L. Ryan, Gerald J. Malloy. Front Row: Sister Marie Breitling, Sister DePaul Tehan, Sister M. Pauline Curry, Margaret S. Adams, Charles E. Berry, Sister Clement Raymond Carey, O.P., Sister Thomas Francis Cushing, C.S.J., Sister Timothy Marie Flaherty, O.S.F., Sister Theresa Daly, C.C.V.I., Sister Mary Simonette Skowron, C.S.S.F. John B. Warner Jr., not present. (See p. 160.)

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NEWS...

Group Practice Fight Started by N.Y. Medics

NEW YORK.—Resolutions aimed at destroying the Health Insurance Plan of Greater New York and like prepayment group practice programs were approved here last month by the house of delegates of the New York State Medical Society.

Dr. George Baehr, H.I.P. president, said the resolutions, if sustained by the Judicial Council of the American Medical Association, would make unethical thousands of physicians voluntarily practicing in group prepayment plans with hospitals, industrial, union, fraternal and other group programs.

The state medical society resolutions provided that:

1. Advertising aimed at getting patients for a panel of physicians of a medical care plan, company or other organization should be held unethical.

2. The practice of medicine by physicians on a salary should be restricted to institutions whose patients are public charges.

3. Free choice of physician would be considered violated when the patient must choose from a panel or group of practitioners.

4. Proration of fee between physician and surgeon in a case would be held ethical, where the fee is paid by an insurance company.

The resolutions were presented as revisions to the state code of medical ethics. The state association was to request similar "clarification" of the A.M.A. Principles of Ethics at the San Francisco session later in the month.

In another resolution, the New York State society upheld an action of the Queens County Medical Society censuring one of its members for use of his name in advertising of a prepayment plan.

Interpretation of medical ethics as prohibiting advertising by H.I.P. and similar voluntary plans is itself a violation of the free choice principle, Dr. Baehr charged. Proponents of the resolutions "would deny the public the opportunity to have comprehensive insurance protection against virtually all doctors' bills and deny licensed physicians the right to provide such comprehensive services through prepaid group practice," he declared.

Following the meeting, representatives of prepayment groups suggested they will fight to preserve principles of group practice against attack by organized medicine, possibly on the basis that such restrictions are a violation of the Sherman act. Representatives of the prepayment groups said the fight may be carried, "if necessary, all the way up to the Supreme Court."

N.Y.C. Opens Rehabilitation Service for Elderly Indigents

NEW YORK.—Older patients who are hospitalized will be helped to rehabilitate themselves in the new service for geriatric rehabilitation that has been opened at Goldwater Memorial Hospital, Welfare Island, New York.

The Geriatric Rehabilitation Service, which comprises 100 beds, accepts patients who are medically indigent from anywhere in the five boroughs of New York. The program includes attention to social and emotional problems as well as to physical, and it is planned so as to make maximum use of community resources. The intention of the service is to return as many patients as possible to the community, and, if this is not feasible, to transfer them to other facilities. Patients are not accepted for custodial care.

The project is sponsored jointly by the New York City Department of Hospitals and the New York University Bellevue Medical Center. It is supported by funds made available by the New York Foundation.

Blue Cross Benefits to Osteopathic Hospitals

ST. LOUIS.—Full Blue Cross certificate benefits have been extended to osteopathic hospitals by a policy amendment adopted at the annual meeting of the corporate membership of Group Hospital Service of St. Louis.

The amendment makes it possible for osteopathic hospitals, which were formerly ineligible, to apply for participation as Blue Cross member hospitals. The new provision permits recognition of accredited osteopathic hospitals. It also allows Blue Cross to pay for full certificate benefits for members who are admitted under the care of osteopathic physicians to tax supported hospitals which are listed as Blue Cross service hospitals.

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NEWS...

Tennessee Delegates in Buzz Session, Hoe-Down

(*Continued From Page* 146)

A small hospital forum, headed by Dr. A. F. Branton of Baroness Erlanger Hospital, Chattanooga, then discussed problems facing small hospitals today, especially how to get the medical staff to organize so that smaller hospitals can be accredited.

Friday morning's audience heard Edgar H. Stohler, administrator of Memorial Hospital, Johnson City, discuss the complex effects of human relations on the hospital organization. Mr. Stohler urged administrators to study carefully the complex human interrelationships and the acts of individual employes as they affect the smooth operation of the hospital.

Dr. Kenneth B. Babcock, director of Grace Hospital, Detroit, and recently selected executive director of the Joint Commission on Accreditation of Hospitals, asked the delegates to institute careful studies in their own institutions in an effort to reduce unnecessary use of facilities.

Gordon E. Friesen, senior hospital administrator of the United Mine Workers Memorial Hospital Association, talked on ways of reducing man-hours of hospital personnel. Colored slides showed the use of specific pieces of labor saving equipment in Kitchener-Waterloo Hospital, Kitchener, Ont., where Mr. Friesen was administrator for some years. The slides also included interesting floor plans of some of the new hospitals in the United Mine Workers chain.

TEAMWORK FOR PATIENTS' CARE

Friday afternoon's session was on better teamwork for patients' care. Dr. George L. Inge of Knoxville, speaking from the staff physician's point of view, told delegates that petty bickering among doctors, between doctors and administrator, and among department heads is a sure sign of poor morale and shows lack of teamwork. Elizabeth Killeffer of Knoxville, past president of the Tennessee Nurses' Association, urged administrators to establish clear and simple lines of communication and to encourage more joint planning by department heads. Speaking from the standpoint of the dietitian, Miss C. Robinson, director of nutrition of the state department of mental health, urged hospital administrators to get doctors and dietitians to work out standard special diets together.

Ralph Stone, chief pharmacist at Vanderbilt Hospital, Nashville, asserted: "When all department heads and employes really understand what the hospital stands for and what goes on within its walls, each one will be more inclined to work as a team member. Genuine interest cannot blossom from nothing." He described a monthly dinner meeting of all department heads held at Vanderbilt at which each department head in turn explains the working of his department. This is always followed by a discussion period.

Silvia Aliberti, registered record librarian at Oak Ridge Hospital, described the process involved in setting up rules which the medical staff, the administrator, and the board of trustees will agree must be performed if complete medical records are to be obtained on time. Lorane Roberts, executive housekeeper of East Tennesee Tuberculosis Hospital, Knoxville,

pointed out that the most important thing in developing full teamwork is to have an able, experienced administrator at the top of the organization structure. "Then we must train and teach employes to get along on friendly terms with everyone." O. F. Morris, chief accountant of St. Mary's Memorial Hospital, Knoxville, declared that operating cost data must be given to and interpreted for all department heads, and the accountant must help the administrator develop financial and operational reports that will serve as operating controls.

James E. Ferguson, administrator of East Tennessee Tuberculosis Hospital, pointed out that administrators must never play favorites and must realize that all departments are equally important in developing high-grade patient care. "Administrators must be supersalesmen," said Mr. Ferguson. Allan Gump, president of the board of Johnson City Memorial Hospital and president of a bank in Johnson City, substituted for Roy McDonald of Chattanooga as the trustee representative on the afternoon's panel. "Pick board members carefully," said Mr. Gump "and be sure that every member is thoroughly informed as to what his job is before he is actually elected to the board." Mr. Gump pointed out that lack of knowledge of the true purposes and functions of a hospital is often at the base of the lack of interest on the part of board members.

As a relief from the usual formal banquet and speech making, Friday evening featured an old-fashioned Tennessee square dance and hoe-down. A buffet supper was served before the evening's festivities started. Dr. Malcolm T. MacEachern of Chicago won a prize as the most appropriately dressed male member at the hoe-down.

The Saturday morning session was a buzz session conducted by Everett W. Jones, publisher of the *Hospital Purchasing File,* Chicago, who was assisted by John Tallmadge of Knoxville, Ernest Bliss of Jackson, Norman Brough of Kingsport, M. Gaylord Hubbard of Nashville, and Joseph Kreycik of Paris. These men acted as associate chairmen, directing the conversations at the various table groups.

Out of seven or eight pressing problems suggested by the various groups, three were selected for final and thorough discussion. Tables No. 1 and 2 handled the problem of staff organization and control of medical standards. Tables No. 3 and 4 discussed credit and collection problems, and Table No. 5 considered personnel shortages.

Leonore Seay, recorder for Table No. 1, reported the following as important in the effort to improve medical standards: (1) Good complete medical records are essential; (2) conferences of all hospitals in a given area to discuss the problem would help; (3) institutes for trustees should be conducted; (4) staff doctors must be educated to realize that accreditation of any hospital is essential; (5) perhaps a traveling counselor might be provided for each area in a given state to work with hospital administrators on staff organization and control of medical standards.

William Spear, recorder for Table No. 2, reported lack of concern on the part of national, state and county medical organizations as one of the prime reasons for the problem facing hospital administrators. Too, there is often a lack of proper communication between

the organized medical staff officers and members of the staff. The group agreed that an overpowering public demand for accreditation must be created in order to get the doctors to cooperate fully. It was suggested that third parties paying for hospital care might consider restricting payments to those hospitals fully accredited. The group asked for more help from the American Medical Association, the American College of Surgeons, and the American College of Physicians in getting their members in line on the subject of accreditation. It asked that medical students, interns and residents be given a complete orientation on the subject of hospital accreditation.

Ben Haynes, recorder for Table No. 3, reporting on credits and collections, said the group felt that one of the biggest problems is lack of public understanding on the financing of hospitals. All hospitals in an area should establish a policy on credits and collections, the group decided, and this policy should be made known to everyone in the community. Use of local credit and collection bureaus was urged along with the suggestion that all hospitals in a given area exchange credit facts. The report closed by urging everyone to get out and sell Blue Cross.

C. W. Wright, as recorder for Table No. 4, said that part of the hospitals' credit and collection problem is due to inadequate prior education of the patient about hospital charges and payment of the bill. The group agreed that, if staff doctors fully understood the problem, they could be of great help in getting the proper facts to the patient. The possibility was suggested of issuing credit cards on a national basis as do the "drive yourself" stations.

Joe Kreycik, leader at Table No. 5, also acted as recorder on the problem of personnel shortages. Everyone at his table agreed that there's not enough local recruiting effort and that there's a great tendency on the part of individual hospitals to sit back and let the national organizations do it all. Informed, thoroughly experienced, able supervisors play a large part in recruiting and retaining good employes, the group declared. It urged that the federal government pay its fair share of educating nurses.

Dr. Malcolm T. MacEachern closed the convention with a brief talk on the accreditation program. He pointed out that the original program called for a yearly expenditure of $100,000 and that both the American Medical Association and the American Hospital Association said they couldn't possibly find the money for it. The American College of Surgeons then agreed to provide the money for the program. "What a great improvement it is today to have all the national medical and hospital organizations involved in a joint effort to strengthen the accreditation program." A.M.A. members and officers used to knock the A.C.S. accreditation program whereas today they are wholeheartedly back of the program." However, there is still a considerable number of A.M.A. members who are bucking full accreditation, he declared. Dr. MacEachern predicted that 10 years from now no hospital of 25 beds or more will be able to exist unless it is fully accredited by the Joint Commission. At the conclusion of the program Dr. MacEachern was presented with an honorary membership certificate in the Tennessee association.

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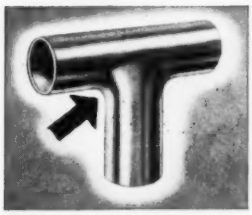

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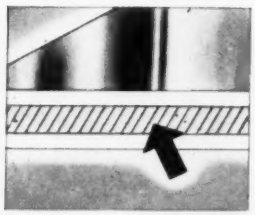

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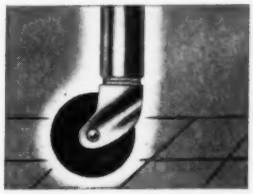

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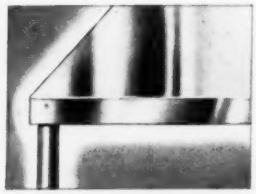

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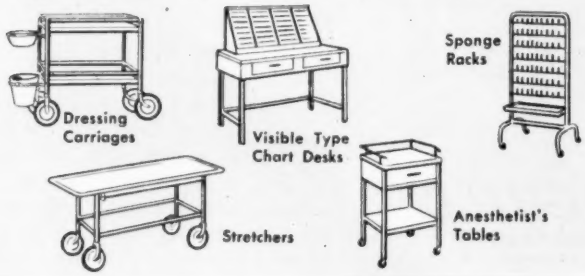

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NEWS...

Dr. Long Lambastes Routine Lab Tests

NEW YORK.—Unnecessary laboratory procedures ordered by physicians were criticized sharply in an address here last month by Dr. Perrin H. Long, chairman of the department of medicine of the State University of New York College of Medicine.

In an address to the Medical Society of the State of New York, Dr. Long said laboratory procedures should be reserved for difficult cases and never considered as routine measures.

Dr. Long said he was "appalled" at the number of laboratory tests ordered in case work-ups for patients suffering from diseases that should be diagnosed easily.

"Laboratory work is expensive to the patient if he has to pay for it, and costly to the hospital if the patient does not pay for it," Dr. Long declared. "Furthermore, the extensive reliance upon laboratory tests by physicians, instead of using their God-given senses, overloads many laboratories, with the result that the accuracy and efficiency of the laboratory workers decrease.

"It must be kept in mind that the reliability of a laboratory test is dependent on the skill, accuracy and integrity of the individual who does it," Dr. Long concluded.

Raymond P. Sloan Gets LL.D. From St. Lawrence

Raymond P. Sloan

Raymond P. Sloan, president of the Modern Hospital Publishing Company, Inc., has been awarded an honorary degree of doctor of laws by St. Lawrence University, Canton, N.Y., at the university's recent commencement ceremonies.

Joseph J. Romoda, dean of the college of letters and science of St. Lawrence University, read the citation:

"Nationally known and respected authority on hospital administration and public health, he has devoted a lifetime to the service of his fellowmen. As lecturer, editor, writer and publisher, he has helped to educate the American people to an understanding of the problems involved in these fields of endeavor. He has built upon a foundation of rich practical experience and vital human relations.

"Because of his outstanding record of public service, it is altogether fitting that we now welcome him to St. Lawrence University as an adoptive son."

Mr. Sloan's activities in the field of hospital administration and public health were recognized in 1946 by Colby College which conferred on him the honorary degree of doctor of humane letters, and by the American College of Hospital Administrators which made him an honorary fellow in 1953.

P.H.S. Making Inventory of Nursing Homes

BALTIMORE.—A national inventory of nursing homes and related facilities is being made by the Division of Hospital Facilities, Public Health Service, in order to determine criteria for developing state programs for the care of the chronically ill. Previously the lack of exact knowledge about the existing

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facilities and criteria against which to measure them had hindered the development of state hospital programs under the Hill-Burton act.

This inventory will complement the more extensive survey in the same field being conducted by the Commission on Chronic Illness.

Residencies Announced for 1954 Graduates

Recent graduates in university programs in hospital administration have received their assignments for administrative residencies or administrative assistantships. Those announced before press date are as follows:

Northwestern University.—George C. Allen, Provident Hospital, Chicago; Charles E. Banish, Mount Sinai Hospital, Chicago; Jessie Hargus Bartlett, Methodist Hospital, Memphis, Tenn.; Alan B. Campbell, Wesley Memorial Hospital, Chicago; Pasqual A. Capitanelli, Veterans Administration Research Hospital, Chicago; Dr. Sabih Djazzar, University Hospital, Ann Arbor, Mich.; Jack H. Docktor, Albert Einstein Medical Center, Philadelphia; Kayo R. Dokken, White Cross Hospital, Columbus, Ohio; Albert M. Donnell, Wesley Hospital, Oklahoma City, Okla.; Mose I. Ellis, Mount Sinai Hospital, Chicago; Welch England, Harrisburg Polytechnic Hospital, Harrisburg, Pa.

Brady K. Fowler, Department of Health and Hospitals, Denver; Newell E. France, Herrick Memorial Hospital, Berkeley, Calif.; Maura Giménez-Merlo, not assigned; Robert J. Grischy, Memorial Hospital of DuPont County, Elmhurst, Ill.; Artee F. Hammond, Freedmen's Hospital, Washington, D.C.; William D. Hamrick, Methodist Hospital, Houston, Tex.; James L. Henry, Memorial Hospital, Houston, Tex.; Maudie L. Horne, Public Health Service, New Orleans; Robert L. James, St. Francis Memorial Hospital, San Francisco; Samuel K. Johnson, Harris Memorial Hospital, Fort Worth, Tex.

Daniel J. Kehoe, Harper Hospital, Detroit; Nolan R. Lackey, Welborn Memorial Baptist Hospital, Evansville, Ind.; Thomas F. McCarthy, not assigned; John E. Milton, Presbyterian Hospital, Chicago; Robert T. Moore, Newton-Wellesley Hospital, Newton Lower Falls, Mass.; Forrest Neumann, Methodist Hospital, Gary, Ind.; Donald H. Pound, Edward W. Sparrow Hospital, Lansing, Mich.; Joseph C. Rodgers, Columbia Hospital, Milwaukee; Andrew W. Saphiloff, Vanderbilt University Hospital, Nashville, Tenn.; Earl G. Skogman, Medical Center Hospital, Tyler Tex.; Talmage D. Smith Jr., Presbyterian Hospital Center, Albuquerque, N.M.; John E. Strawbridge, Flower Hospital, Toledo, Ohio; Mary J. Sullivan, Victory Memorial Hospital, Waukegan, Ill.

Masaichi Tasaka, Highland Park Hospital, Highland Park, Ill.; Raymond L. Tate, Magic Valley Memorial Hospital, Twin Falls, Idaho; John H. Wisda, Sandusky County Memorial Hospital, Fremont, Ohio; Ernest S. Williams, Westlake Hospital, Melrose Park, Ill.; Gerald D. Woods, Waverly Hills Sanatorium, Waverly Hills, Ky.

St. Louis University.—Margaret S. Adams, Bethany Hospital, Kansas City, Kan.; Edward A. Behrman, St. Joseph's Hospital, Flint, Mich.; Sister Marie Breitling, St. Paul's Hospital, Dallas, Tex.; Sister M. Pauline Curry, Good Samaritan Hospital, Dayton, Ohio; Robert M. Hofmann, University of Louisville Medical Center, Louisville, Ky.; Joseph B. Mackey, Methodist Hospital, Memphis, Tenn.; Gerald J. Malloy, Touro Infirmary, New Orleans; John L. Ryan, Spohn Hospital, Corpus Christi, Tex.; Ronald S. Simon, Loretto Hospital, Chicago.

Sister Clement Raymond Carey, O.P., St. Vincent's Hospital, New York; Sister Thomas Francis Cushing, C.S.J., St. Francis Hospital, Hartford, Conn.; Sister Theresa Daly, C.C.V.I., Mercy Hospital, Oklahoma City, Okla.; Sister Timothy Marie Flaherty, O.S.F., St. Vincent's Hospital, New York; Sister Mary Simonette Skowron, C.S.S.F., St. Francis Hospital, Pittsburgh; Harold W. Steadham, Jefferson-Hillman Hospital, Birmingham, Ala.; Fred J. Stonage, Veterans Administration Hospital, Houston, Tex.; Sister DePaul Tehan, Providence Hospital, Detroit; John B. Warner Jr. and Paul R. Wozniak, Jewish Hospital, St. Louis.

University of Chicago.—Edward S. Glavis III, Citizens Hospital, Barberton, Ohio; Ernest C. Gray Jr., University Hospitals, Cleveland; Marion J. Holl, University Hospitals, Madison, Wis.; Jack H. Houtz, General Rose Memorial Hospital, Denver; David A. Johnson, University Hospital, University of Maryland, Baltimore; William L. Loving, City Hospital, Cleveland; Stuart C. Mount, administrative position; Edward L. Naegeli, University Hospital, Columbus, Ohio.

Erwin Rembolt, Hospital of Medical College of Evangelists, Los Angeles; Dr. Edwin F. Rosario, deputy superintendent of Medical College Hospital, Nagpur, India; Edward W. Weimer, Dallas City-County Hospital, Dallas, Tex.; Jack A. White, Highland-Alameda County Hospital System, Oakland, Calif.; Le Roy Williams, Hillcrest Medical Center, Tulsa, Okla.

University of Toronto.—Norman R. Dearlove, Toronto Western Hospital, Toronto, Ont.; Edward G. Hertfelder, Jackson Memorial Hospital, Miami, Fla.; Cecil H. Kennedy, Kingston General Hospital, Kingston, Ont.; Bernard McCarthy, Toronto East General Hospital, Toronto, Ont.; Ronald J. C. McQueen, Peterborough Civic Hospital, Peterborough, Ont.; John M. Partlo, Kitchener-Waterloo Hospital, Kitchener, Ont.

Donald A. Robertson, St. Mary's Hospital, Montreal, Que.; Gdalyah B. Rosenfeld, not assigned; Sister Mary Fintan, St. Michael's Hospital, Toronto, Ont.; Sister M. Janet, St. Joseph's Hospital, Toronto, Ont.; Peter E. Swerhone, Calgary General Hospital, Calgary, Al.; Gerald P. Turner, St. Boniface Hospital, Winnipeg, Man.

NEWS...

Red Cross Leaves N.Y. Blood Bank Group

(*Continued From Page* 146)

Blood Bank Commission sponsors the association.

Under the new Blood Assurance Program, an individual giving a pint of blood is assured of all the blood he may need for himself during the year, or four pints for a family member.

When an association official indicated it was expected that 65 to 70 per cent of blood collected under the program would remain as surplus, to be sold to hospitals at $14 a pint for resale to patients at the hospital's regular charges of approximately $35 a pint, Dr. Markel resigned from the board of directors of the association, stating in his letter of resignation that "its purposes have changed and are no longer in accord with the Red Cross policy of increasing the supply of blood and derivatives available to the public."

Furthermore, Dr. Markel charged, public statements by association officials "indicate that they disapprove of and are making a concerted effort to weaken the Red Cross blood program."

This was thought to be a reference to an address on May 10 by Dr. Andrew Eggston, president of the state medical society and a member of the board of directors of the Blood Banks Association, who said the philosophy of free blood to all regardless of ability to pay, as promulgated by the Red Cross, "smacks of socialism and should never have been approved by organized medicine."

Dr. Markel's letter of resignation was interpreted as having charged the Blood Banks Association with "commercialism," although he did not use the term himself.

Speaking for the association, Dr. Kenney said the charge of commercialism "slanders the humanitarian principles of the medical profession and the motives of the Blood Banks Association officers and committees who are working on a voluntary, unpaid basis."

Dr. Markel's assertion that the purposes of the association had changed and were no longer in accord with the Red Cross policy were "utterly inconsistent with the facts," Dr. Kenney said, "not in the public interest and most unfair to the association, of which he has been a full voting director since its inception."

An association official said hospitals belonging to the association would pay a $2 fee for each donor referred under the blood assurance plan. Transfusion and processing would cost approximately $14 a pint, he said. The association has no control over the amount hospitals may then charge for such blood when it is purchased.

"The association sells no blood and owns no blood banks," Dr. Kenney stated. Instead, he added, it serves as a clearinghouse for exchange of blood needed by member banks and a means of assuring individual donors and their families of needed blood in return for earlier donations.

Asserting that the association program was aimed at increasing the supply of blood in member banks, an official said: "One is led to the conjecture that the public response to this appeal for donors has been so favorable that the Red Cross fears our plan may prove more popular than its own."

HERE'S HOW 325 HOSPITAL DIETITIANS USE PAPER CUPS!

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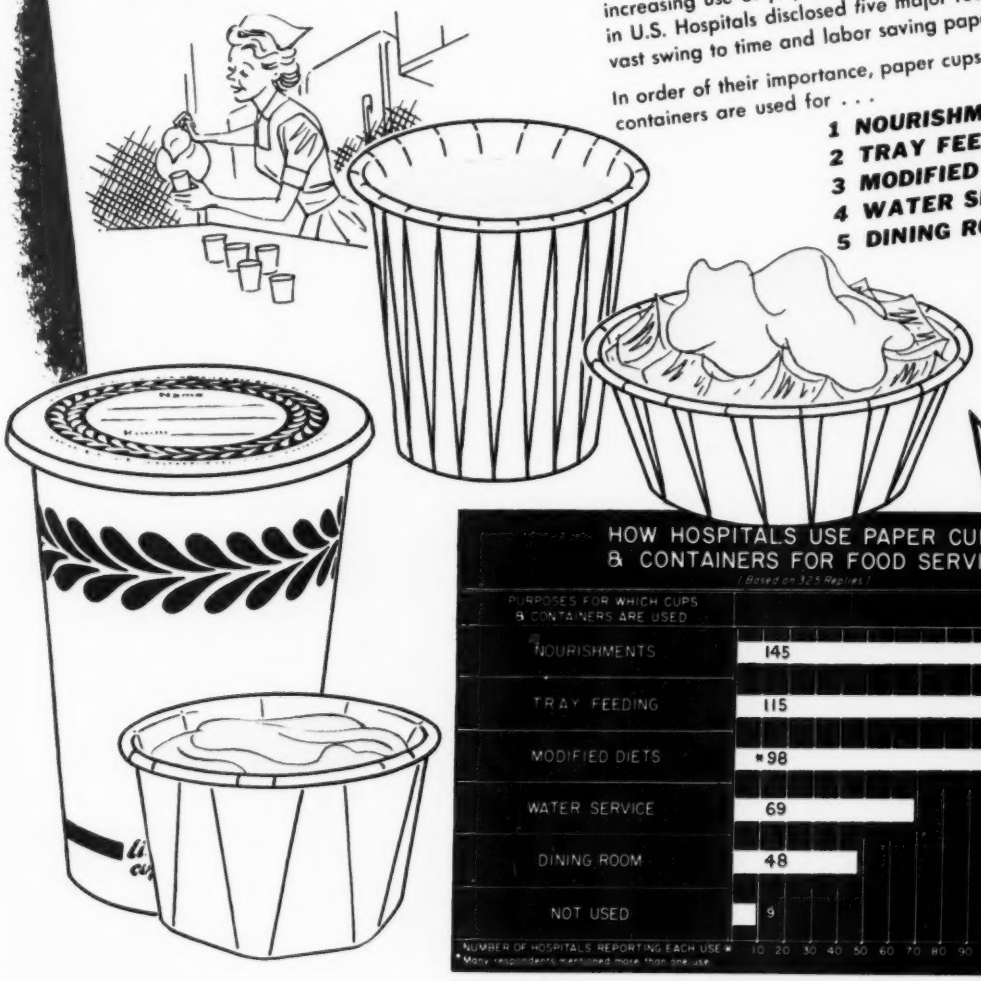

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NEWS...

Medical Profession and Public Must Be Shown Value of Accreditation: Crosby

(*Continued From Page 68*)

inspection and evaluation program conducted by the commission, and Dr. Anthony J. J. Rourke, director of the Hospital Council of Greater New York. Answering a question from the floor, Dr. Rourke defended the commission's policy of adopting uniform standards for small and large hospitals. "No matter where a human being is hospitalized," he declared, "whether in a 25 bed or 500 bed institution, he needs the same quality of medical care, and must get it."

Robert G. Boyd, administrator of the Morristown Memorial Hospital, Morristown, N.J., and retiring president of the New Jersey Hospital Association, was named president of the Middle Atlantic Hospital Assembly during the convention, which was attended by a record crowd of 2650. Other officers named by the assembly were: vice president, J. Russell Clark, Brooklyn Hospital, Brooklyn, N.Y.; treasurer, John F. Worman, executive secretary, Hospital Association of Pennsylvania, Harrisburg, and secretary, J. Harold Johnston, executive director, New Jersey Hospital Association, Trenton, N.J.

NEW JERSEY OFFICERS

Officers named by the New Jersey Hospital Association were: president, Frank P. Sauer, director, Muhlenberg Hospital, Plainfield; president-elect, John W. Kauffman, administrator, Princeton Hospital, Princeton; vice president, Cora E. Gould, administrator, Orthopaedic Hospital, Orange. Dr. Abram L. Van Horn, medical director, Kate Macy Lodd Convalescent Hospital, Far Hills, was reelected treasurer, and J. Harold Johnston was reelected executive director and secretary.

Ralph E. Vannozzi, administrator, Bridgeton Hospital, Bridgeton, will serve another term on the association's board of trustees. New board members are Joseph A. Mattson, director, Passaic General Hospital, Passaic, and Rt. Rev. Msgr. Alfred Jess, Bishop's representative for hospitals, Camden.

John W. Kauffman and Robert G. Boyd were named delegates to the American Hospital Association, and Nelson R. Henson, administrator, Englewood Hospital, Englewood, and Cora E. Gould were named alternates.

PENNSYLVANIA OFFICERS

The Hospital Association of Pennsylvania named the following officers: president, Robert W. Gloman, administrator, Wilkes-Barre General Hospital, Wilkes-Barre; first vice president, George A. Hay, administrator, Woman's Medical College of Pennsylvania, Philadelphia; second vice president, Sidney Bergman, executive director, Montefiore Hospital, Pittsburgh; treasurer, Joseph W. Bishop,

Frank P. Sauer, president, New Jersey association, and administrator, Muhlenberg Hospital, Plainfield; Jane Boyd Thomas, retiring president, Hospital Association of Pennsylvania; Robert G. Boyd, new president, Middle Atlantic Assembly, and administrator, Memorial Hospital, Morristown, N.J.; Dorothy Pellenz, former president, Hospital Association of New York State, and superintendent, Crouse-Irving Hospital, Syracuse; Robert W. Gloman, president, Hospital Association of Pennsylvania, and administrator, Wilkes-Barre General Hospital, Wilkes-Barre.

New study confirms
T. E. D. Elastic Stocking Routine SAVES LIVES

In a study of 9,917 hospital patients, the expected incidence of fatal pulmonary embolism was reduced 65% at a cost of about 2½¢ per bed per day.

Conclusions reached earlier—that routine use of T.E.D. Elastic Stockings significantly reduces incidence of fatal pulmonary embolism among hospital patients—have been amplified.

In new studies at Massachusetts Memorial Hospitals in Boston, T. E. D. Elastic Stockings were applied routinely to *all* patients over 21 years of age admitted to the hospital for more than 24 hours (except in cases of ischemic vascular disease of the legs in which use of the stockings is contraindicated). Data on the incidence of pulmonary embolism was carefully compiled and conservatively interpreted.

The Result: Expected incidence of fatal pulmonary embolism was reduced by 65%.

The majority of fatal emboli result from circulatory stasis incident to bed rest. In most cases they originate in the deep calf veins of the leg—an area in which prophylaxis is easily accomplished by simple compression of the leg.

T.E.D. Elastic Stockings, a new type of inexpensive elastic stockings, provide this compression efficiently and at low cost. They exert just enough pressure to speed blood flow through the deep calf veins, thus minimizing clot propagation. T. E. D. Stockings were developed exclusively by Bauer & Black in cooperation with Massachusetts Memorial Hospitals.

A complete report of the above study appeared in the New England Journal of Medicine. You may have a reprint of this article for your files by writing to Bauer & Black Research Laboratories, 309 W. Jackson Blvd., Chicago 6, Ill.

Specimen of deep calf veins opened to show ante mortem clot filling peroneal and posterior tibial veins. From such clots fatal and non-fatal pulmonary emboli result. *(Specimen photograph courtesy of Joseph R. Stanton, M. D., Massachusetts Memorial Hospitals and Boston University School of Medicine.)*

COST OF T. E. D. STOCKINGS AVERAGES LESS THAN 2½¢ PER BED PER DAY

The quantity price of T.E.D. Elastic Stockings is only $2.45 per pair. When you furnish 3 pairs per active bed per year the cost averages only 2½ cents per day.

T. E. D.®

ELASTIC STOCKINGS

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administrator, Hahnemann Hospital, Scranton, and trustees, Rose M. Cullen, administrator of Children's Heart Hospital, Philadelphia, and C. Robert Youngquist, administrator, Sharon General Hospital, Sharon.

New delegates to the A.H.A. are: Charles S. Paxson Jr., superintendent, Delaware County Hospital, Drexel Hill; E. Atwood Jacobs, administrator, Reading Hospital, Reading, and Walter J. Rome, superintendent, Children's Hospital, Pittsburgh. Olin A. Evans of New Kensington, Mabel Barron of Ellwood City, and Robert A. Kumpf of Lewiston were elected alternates.

In another general session, the assembly came to grips with another perennial problem of hospital operation—the nursing shortage. Hospitals must face up to the fact that the shortage will continue to be severe, Dr. Albert W. Snoke, director of Grace-New Haven Community Hospital, New Haven, Conn, told the assembly. It is estimated that from 55,000 to 60,000 nursing graduates will be needed every year to meet the needs of the expanding patient population, Dr. Snoke said. "Since only 47,000 nurses were turned out in our biggest year, I believe such a goal is impossible to attain," he said. "We shall have to consider other ways of handling the problem."

Among methods suggested for meeting the continuing shortage were accelerated training programs and wider use of nurse's aides, shorter programs of education for graduate nurses, more efficient use of practical nurses, and better wages and working conditions.

Commenting on the divided opinion among hospital and nursing authorities on the subject of accreditation for nursing schools, Dr. Hugo Hullerman, director of hospital service for the United Hospital Fund of New York City, said the nursing school accreditation program is with us permanently." "All nurses who plan on a formalized type of nursing education eventually will want to attend an accredited school," he said.

Rutledge of Dallas Is New A.S.T.A. Head

MACKINAC ISLAND, MICH.—J. Carroll Rutledge of E. H. McClure Company, Dallas, Tex., was elected president of the American Surgical Trade Association at the 52d annual meeting here last month. He succeeded Robert E. Anderson Jr. of Powers and Anderson, Richmond, Va., who has been president for the last three years.

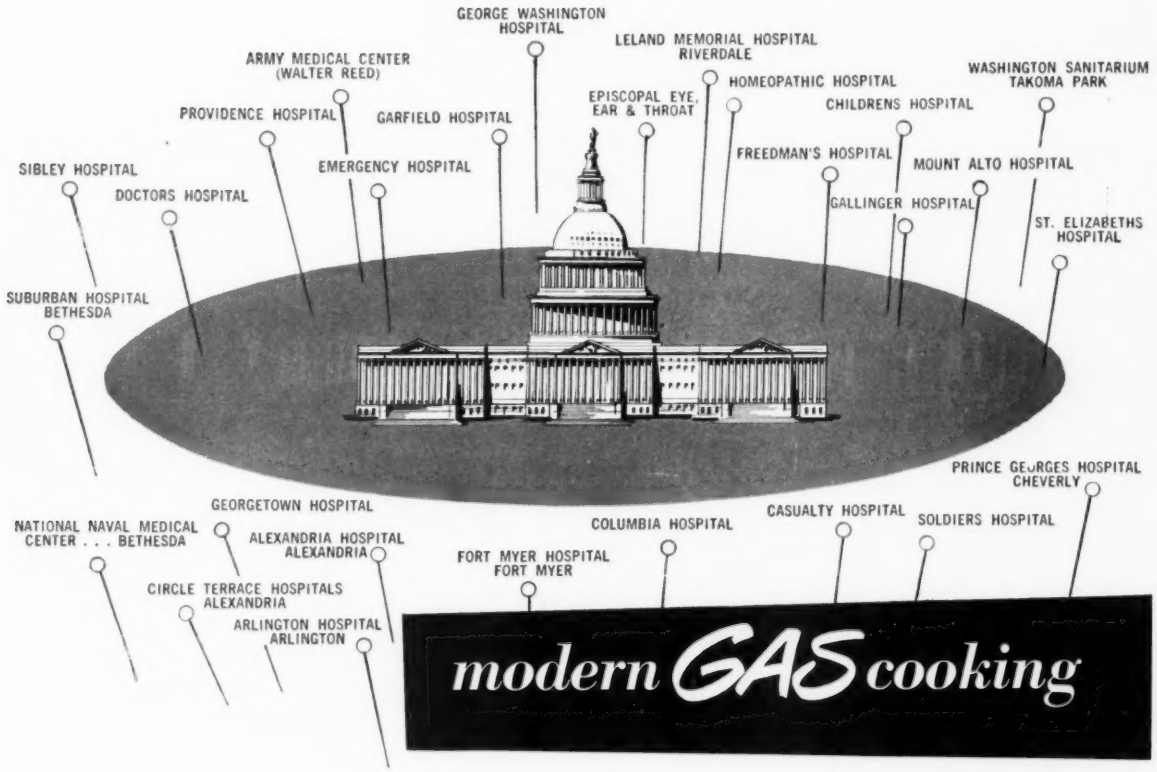
Other officers named by the association were: vice president, Herbert L. Crowley Jr., Crowley and Gardner Company, Boston; directors: Harry H. Carnahan, Medical Arts Supply Co., Huntington, W. Va.; Julius Berbert, George Berbert and Sons, Inc., Denver; Howard R. Schuemann, Schuemann-Jones Co., Cleveland; Dale C. Deckert, Deckert Surgical Co., Santa Anna, Calif.; Mr. Anderson and Mr. Crowley.

More than 350 A.S.T.A. members, manufacturers representatives, and guests attended the meetings and enjoyed the recreational and social activities planned for the group.

Among the principal speakers were Dr. Ben F. Bills of Northwestern University, who talked on sales technics, and H. W. Adkins, vice president of Yahr-Lange, Milwaukee, who discussed purchasing and inventory control.

Unanimous choice

in Washington, D.C. Hospitals



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It's by choice—not by chance—that every hospital in Washington and its adjacent areas of Maryland and Virginia uses GAS for cooking. Executives of the city's new, most modernly equipped hospitals are in unanimous agreement with those of Washington's older institutions on the many important reasons why GAS has been their selection for food preparation and service.

One of the important reasons is the modern, streamlined compactness of Gas Cooking Equipment which fits into any type of kitchen, large or small.

Another reason is the fast action obtainable with modern Gas Cooking Equipment—high-speed deep-fat frying, broiling by blue flame which seals in natural juices and vitamins, instant on-off heat for top-burner cooking.

But this same efficient Gas fuel, under precise automatic control, permits slow roasting of meats and poultry in constant-temperature ovens so that every pound of raw meat produces the maximum number of generous cooked servings.

Dieticians, food service administrators, and other hospital officials in metropolitan Washington, as well as in other cities coast to coast, will cite many additional vitally important reasons why GAS is best, by any standard of comparison, for every cooking requirement. They're important reasons, too—and your Gas Company or your kitchen equipment specialist will be glad to sum them up quickly for you.

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NEWS...

Bottom Row: Vice President D. S. Riley, Big Spring; Trustee Sister Mary Annella, Abilene; President John G. Dudley, Houston; Retiring President W. U. Paul, El Paso; President-Elect Boone Powell, Dallas. Top Row: Trustee Earl Benson, Odessa; Trustee Bolton Boone, Dallas; Trustee C. H. Rugeley, Wharton; Treasurer H. M. Cardwell, Lufkin; Trustee J. Richard Gates, Gilmer. Trustee T. H. Morrison Jr., Harlingen, was not present when photograph was taken.

Texas Observes Jubilee by Breaking Record

HOUSTON, TEX. — All attendance records were broken at the Silver Jubilee of the Texas Hospital Association at the Shamrock Hotel in May. Almost 2000 delegates were in attendance at the meetings of the Texas Hospital Association, the Texas Association of Hospital Pharmacists, the Texas Association of Medical Record Librarians, and the Texas Association of Hospital Auxiliaries. An unusually large number of commercial exhibits was displayed advantageously in the convention exhibit hall of the hotel.

Because of the ever increasing importance of medical records in the Joint Commission on Hospital Accreditation's program, the sessions of the medical record librarians were unusually well attended. Dr. Edwin L. Crosby of Chicago told the medical record librarians that 12½ per cent of the total accrediting points are devoted to their department. He warned them against assuming responsibilities for evaluating records instead of working with the administrator to see to it that staff doctors do this evaluation. The standard nomenclature of disease is the best available diagnostic index, he said, recommending also the standard forms worked out by the A.H.A. and their own group. He discouraged use of the so-called "check off" form.

In answering questions from the floor, Dr. Crosby said that it is perfectly all right for an extern to write physicals and histories if and, only if, the attending doctor signs this part of the history, indicating that he has read the notes of the extern and approves them. In answer to another question from the floor, Dr. Crosby emphatically asserted that the medical record librarian cannot take a patient's history. This must be done by the attending doctor, extern, intern or resident on the staff.

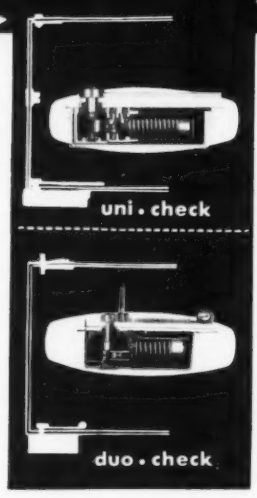
Julia C. Kasmeier, educational secretary of the Texas Board of Nurse Examiners, addressed the opening Tuesday morning session on trends in nursing education and service. She warned that the great population increases in the Gulf State area will demand more and more of all types of hospital personnel. She urged full support of collegiate schools of nursing so that the hospital world will be able to get enough nursing administrators and teachers. "Hospitals must be relieved in part at least of the financial burden of nursing education and training," she said. Miss Kasmeier asked hospital administrators and nursing administrators to combine in studying nursing functions so that the best use can be made of all levels of nursing ability. Statewide and local nurse student recruitment programs must be coordinated and intensified, she said.

Walter McBee, head of the Texas Blue Cross and Blue Shield plans, warned delegates that neither Blue Cross nor hospitals are popular with patients who have restricted coverage policies. "Thirteen years ago," declared Mr. McBee, "I told you that hospitals

all interior room doors too!

...should close automatically with RIXSON closers concealed in the rigid floor

installed, they really cost no more



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could do more to promote and sell Blue Cross than all the Blue Cross salesmen combined. That statement is just as true today. The greatest contribution hospital administrators can make to Blue Cross is to sit down with all key people in the hospital and sell the Blue Cross philosophy to them."

Dr. Frank R. Bradley, administrator of Barnes Hospital, St. Louis, and A.H.A. president-elect, told the convention that some of our early hospitals have declined in importance because of the lessening of their spirit of compassion and charity.

"If the modern hospital is to survive it is going to have to do more true charity work," Dr. Bradley said. "I argue that the survival of the voluntary or church hospital depends upon humanitarianism, sustained and devoted service to the public.

"Gamble a little," Dr. Bradley advised. "When you say this guy has no money and send him to the city hospital, you speed socialized medicine."

Mrs. Oscar Yellott, president of the Texas Nursing Home Association, urged hospital people to help nursing home operators put through licensing laws administered by departments of health rather than by social welfare departments in the various states. She vigorously attacked dirty politics and its influence on the hospital and health fields. Mrs. Yellott described the long fight in Texas for proper state standards to govern nursing homes and to put out of business some of the nursing homes that were a disgrace.

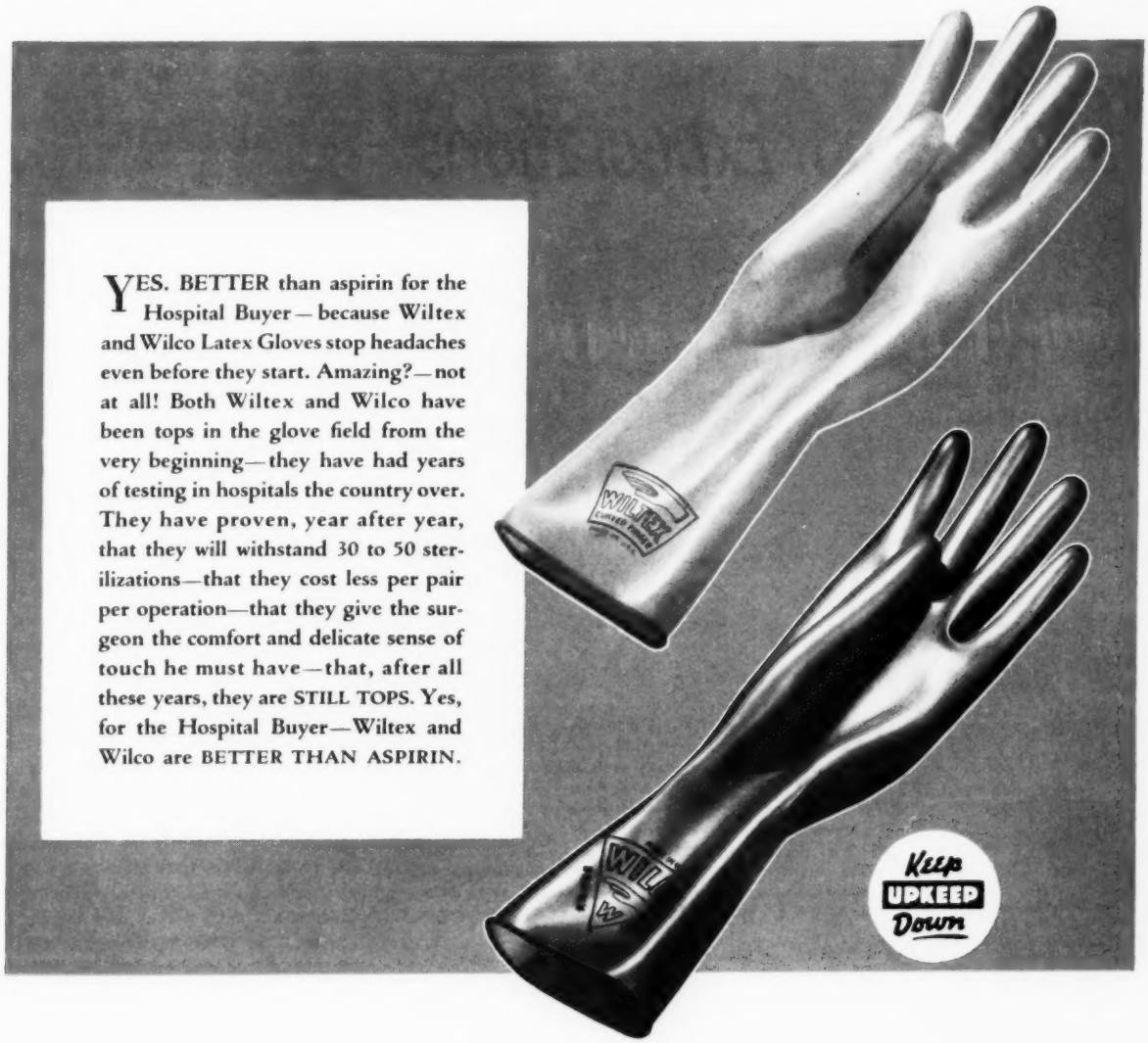
Mrs. C. A. Dwyer, president of the Texas Association of Hospital Auxiliaries, asserted that the most gratifying of all auxiliary activities is the voluntary service done in hospitals. Women enjoy doing the many little things for patients, doctors and employes that regular employes lack time to do.

Chaplain Joe F. Luck of Memorial Hospital, Houston, recommended that every hospital of 100 beds or more have a full-time chaplain. "In order to be successful in the ministry of Christ to hospital patients, the chaplain must have special clinical training in a hospital. Illness is more than a battle with bacteria. It is a spiritual and mental crisis. The simple art of listening is one of the chaplain's most effective tools," he declared.

In reporting on a special study made by a committee on the shortage of professional personnel, Dr. Earl Collier, committee chairman, described a modified R.N. diploma nurses' training program recently worked out by that committee and the Texas Board of Nurse Examiners. This modified program requires only 890 hours of classwork instead of the usual 1400 hours. "Now," challenged Dr. Collier, "it's up to doctors, hospitals and the general public to recruit student nurses for the new program."

In discussing Dr. Bradley's remarks on charity work in hospitals, Dr. Everett C. Fox, chairman of the economics committee of the Texas Hospital Association, agreed that hospitals should do more charity work but only if the community provides from taxation or charity gifts the funds to pay for such care. The Texas Medical Association, Dr. Fox pointed out, agrees that its members should care for outright indigents and medical indigents without charge, but believes that the community must provide funds to pay the hospital for the care of these pa-

BETTER THAN ASPIRIN
FOR THE HOSPITAL BUYER



YES. BETTER than aspirin for the Hospital Buyer—because Wiltex and Wilco Latex Gloves stop headaches even before they start. Amazing?—not at all! Both Wiltex and Wilco have been tops in the glove field from the very beginning—they have had years of testing in hospitals the country over. They have proven, year after year, that they will withstand 30 to 50 sterilizations—that they cost less per pair per operation—that they give the surgeon the comfort and delicate sense of touch he must have—that, after all these years, they are STILL TOPS. Yes, for the Hospital Buyer—Wiltex and Wilco are BETTER THAN ASPIRIN.

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tients. He warned, however, that hospitals should try to keep these tax-fund payments at the county level or at least at the state level.

In discussing the same question, Everett W. Jones, vice president of the Modern Hospital Publishing Company, Chicago, declared that operating costs in Texas hospitals are currently running about $20 a day. "Contrasted with this cost," he said, "the voluntary hospitals of the state receive from state, county and city welfare departments just about $11 a day so that the hospital loses $9 on every day's care given to indigent patients. Certainly hospitals want to do more charity work, but how can they until somebody gives them the money?

"In the past we have been taking care of the situation by overcharging pay patients or, worse still, keeping our old employes at low salaries and long hours, thus making them bear a great part of the charity burden," Mr. Jones asserted. He contrasted the situation in Texas with the current procedures in New York State, where operating costs are about $23 a day and receipts from government sources on charity cases $18 a day.

Dr. Edwin L. Crosby, recent director of the Joint Commission on Accreditation of Hospitals and newly appointed executive director of the American Hospital Association, told a general assembly of the convention that members of the American Hospital Association must be greatly concerned with the 49 per cent of registered hospitals that are not accredited, particularly with those members associated with these nonaccredited hospitals.

Dr. Crosby said: "If small hospitals limit patient care to the abilities and qualifications of their medical staffs, then care in small hospitals can be just as good as in the big teaching institutions." Dr. Crosby emphasized the great importance of the tissue, medical record and credentials committees. He said that the fourth vital committee is the joint conference committee of trustees and medical staff members. Dr. Crosby disclosed that the American College of Physicians has appropriated money for a full-time research man to study just what kind of a committee can be appointed and how this committee can evaluate the results of medical care in the departments of internal medicine, pediatrics and obstetrics. This new committee would be similar to the tissue committee studies in the department of surgery.

At the morning session of the last day of the convention, Phil Overton of Austin, legal counselor of the Texas hospital and medical associations, urged hospital people to be good citizens and to participate actively in local, state and federal government affairs. "Keep your congressmen and senators informed of your wishes and beliefs," advised Mr. Overton. "Don't tie up entirely with either the Democratic or the Republican party but vote for the man you consider best for the office." Mr. Overton delivered a vigorous attack on the federal government's hospital and health reinsurance plan. He asserted that national organizations such as the American Hospital Association should refrain from testifying before congressional committees on bills affecting hospitals until the national group finds out what the majority in each state association thinks about the matter under discussion.

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NEWS...

The last afternoon was given over to a buzz session on hospital problems. Everett Jones, publisher of the *Hospital Purchasing File*, Chicago, was aided in this session by Bolton Boone of Dallas, Don Burk of Big Spring, Bill Burton of El Paso, Bill Earngey of Fort Worth, Fred Higginbotham of San Antonio, Carroll McCrary of Tyler, Al Scheidt of Dallas, and Henry Taylor of Marlin.

The groups at the buzz session tables chose payment for indigents, public relations, personnel shortages, medical staff organization, and control of medical standards as the topics for discussion. Dr. Dean F. Wynn, director of the hospital survey and construction division of the Texas State Department of Health, emphasized that the biggest problem encountered in opening up new hospitals under the Hill-Burton program is to convince staff doctors that accreditation of their hospital is essential if the hospital is to enjoy the confidence of citizens in its service area. Albert Scheidt, administrator of the Parkland City-County Hospital, Dallas, said that our greatest opportunity as hospital administrators is to help in lengthening the life cycle. In reaching this goal, he pointed out, our ability to work with others, particularly our ability to stimulate the organized staff of doctors to control its own work, is a "must."

The opening evening of the Silver Jubilee convention was given over to a barbecue at the Pin Oaks Stables just outside of Houston, with entertainment provided by the Harris County Mounted Sheriff's Posse. The posse arrested and incarcerated several well known persons attending the barbecue.

Officers elected are shown in the accompanying photograph.

Among the allied groups, the following presidents were named:

Texas Association of Nurse Anesthetists, Pearl V. Weaver, Houston (reelected); Texas Association of Medical Record Librarians, Margaret Goggan, Methodist Hospital, Houston; Texas Association of Hospital Auxiliaries, Mrs. J. M. Hefner, Dallas; Texas Conference, Catholic Hospital Association, Sister Mary Helen, administrator, St. Paul's Hospital, Dallas; Texas Conference of Operating Room Nurses, Sister Theobalda, Northwest Texas Hospital, Amarillo, chairman.

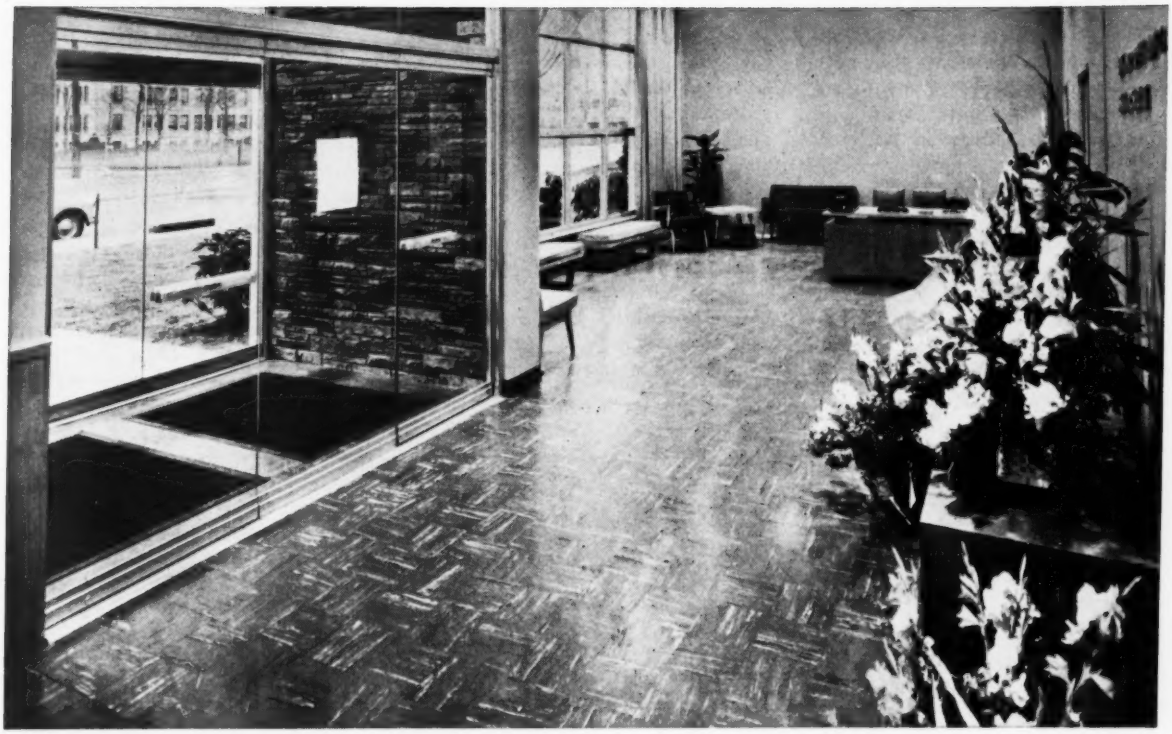
ABOUT PEOPLE

(*Continued From Page* 88)


Howard E. Crouch

Howard E. Crouch, administrative assistant of Memorial Center for Cancer and Allied Diseases, New York, has been appointed administrative assistant of St. Peter's General Hospital, New Brunswick, N.J. Mr. Crouch has an R.N. diploma and a B.S. degree in hospital administration, a master's degree in administration of nursing service and in hospital administration from Columbia University.

Carl D. Rinker, acting executive administrator of Grant Hospital, Chicago, since last March, has resigned to become administrator of Brokaw Hospital, Normal, Ill. His resignation becomes effective July 9. Mr. Rinker was assistant director at Grant under



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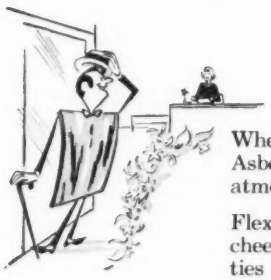

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Hans S. Hansen, now at Fresno, Calif., and before that time was at Worcester City Hospital, Worcester, Mass. He holds a master's degree in hospital administration from Northwestern University and is a member of the A.C.H.A. and the A.H.A.

John C. Hamiter, who has been administrative resident at Jefferson-Hillman Hospital, Birmingham, Ala., is now assistant administrator of Carraway Methodist Hospital, Birmingham. Mr. Hamiter holds a degree in hospital administration from the University of Minnesota.

Gordon A. Friesen, senior hospital administrator of the Memorial Hospital Association of Kentucky, a subsidiary of the United Mine Workers of America Welfare and Retirement Fund, Washington, D.C., resigned last month—reportedly as the result of disagreement with association and fund management on matters of policy and jurisdiction. Mr. Friesen, who was formerly administrator of Kitchener-Waterloo Hospital, Kitchener, Ont., had no immediate plans for a future assignment, it was reported.

Jay M. Atkin, administrative resident at San Diego County General Hospital, San Diego, Calif., has been appointed administrator of Central Community Hospital, San Diego. Mr. Atkin is a graduate of the University of California's course in hospital administration and holds an M.P.H. degree in health education from Michigan.

Dr. John A. Trautman, director of the Clinical Center of the National Institutes of Health, Bethesda, Md., has been named medical officer in charge of Public Health Service Hospital, Fort Worth, Tex. It was under Dr. Trautman's direction that the patient care staff of the research facility at Bethesda was assembled and the first study patients were admitted in 1953. He is succeeded by **Dr. Donald W. Patrick,** who has been medical officer in charge of Public Health Service Hospital, Baltimore, since 1949. Dr. Patrick has taken part in public health research on typhus and spotted fever problems in research laboratories in the District of Columbia and has conducted clinical research in leprosy at Kalihi Hospital, Honolulu.

A. Monroe Owens, administrator of Sanford Clinic and Hospital, Perryton, Tex., has become administrator of the former Loretto Hospital, Dalhart, Tex. The ownership of the hospital has been transferred from the Sisters of the Holy Family of Nazareth to the Coon Estate and the name has been changed to Coon Memorial Hospital.

Marian Jones, superintendent of Maynard Municipal Hospital, Red Cloud, Neb., has announced her resignation. **Mrs. William Olson** is serving as temporary superintendent.

Robert M. Schnitzer, who has been assistant director in charge of hospital relations of the Hospital Service Plan of New Jersey for the last year, has become the director of Kingston Hospital, Kingston, N.Y.

Evelyn Bond, assistant director of nurses at Tacoma General Hospital, Tacoma, Wash., has been appointed administrator of Mary Bridge Children's Hospital there. Miss Bond received her B.S. degree in nursing from the University of Washington and a master's degree in hospital administration from the University of Minnesota.

James Rives, who has been an x-ray and laboratory technician at Carlingville Area Hospital, Carlingville, Ill., has been named administrator of that hospital.

Robert W. Airey, associated with Northwest Hospital Consultants, Inc. in Montana for the last two years, is now

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administrator of McKay Memorial Hospital, Soap Lake, Wash., succeeding **W. A. Chapman,** who has resigned.

Sister Jane has been appointed superior of St. Mary's Hospital, Decatur, Ill., succeeding **Sister Leonissa,** who has been named superior of St. Francis Hospital, Litchfield, Ill.

Robert Pierce Lawton, administrator of Mary Fletcher Hospital, Burlington, Vt., has been named administrator of Danbury Hospital, Danbury, Conn. Mr. Lawton succeeds **Anna M. Griffin,** R.N., who is retiring after 32 years as administrator at Danbury Hospital. Mr. Lawton is a member of the American Hospital Association and of the auditing committee of the New England Hospital Association and is president of the Vermont Hospital Association.

Willis Parr, formerly administrator of Olympic Hospital at Forks, Wash., is now administrator of Rowley General Hospital, Mount Vernon, Wash., succeeding **Mrs. Belle Pomeroy.**

Lester E. Johnson, who has been serving his residency in hospital administration at Baptist Memorial Hospital, Memphis, Tenn., has been named administrative assistant at Baptist Hospital, Alexandria, La. Mr. Johnson received his master's degree in hospital administration from Washington University, St. Louis.

Markam D. Hay, who most recently has been an accountant in Sioux Falls, S.D., and formerly was administrator of hospitals in Grafton, N.D., and Sidney, Mont., has become superintendent of Rockford Township Hospital and Nursing Home, Rockford, Ill. He succeeds **L. P. Kling,** who has resigned.

Department Heads

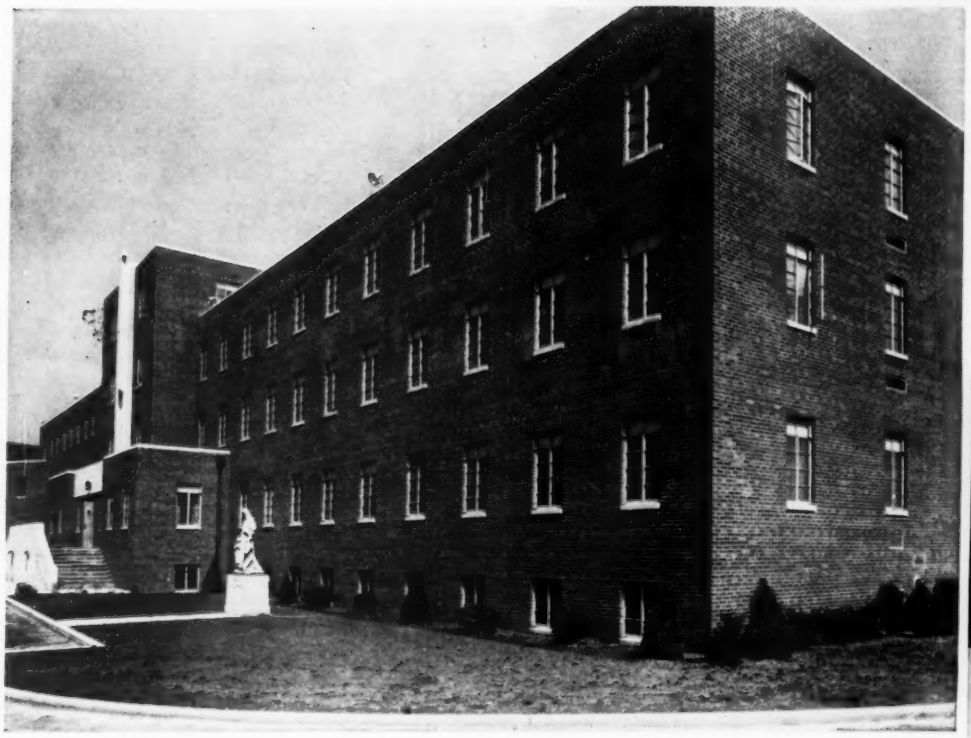
Marcia Lane, who has been a community health educator with tuberculosis and health associations in Connecticut, has been named coordinator of education programs at Beth Israel Hospital, Boston. Miss Lane has a master's degree in public health from the University of North Carolina, and was previously employed by the Public Health Research Institute of New York.

Anne Chapman, who has been assistant professor of nursing at the University of Mississippi and also field consultant on in-service nursing education there, has been appointed administrator to the central staff of associate administrators of the Memorial Hospital Association of Kentucky, Inc. Miss Chapman will be responsible for nursing services and nursing education in the integrated system of 10 general hospitals being developed for beneficiaries of the United Mine Workers of America Welfare and Retirement Fund.

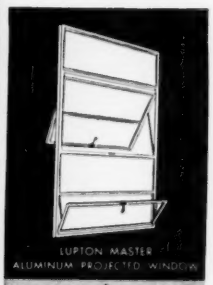
Gloria Alicandri, assistant director of nursing at Jewish Hospital, Brooklyn, N.Y., is now director of nurses at St. John's Episcopal Hospital, Brooklyn, N.Y. Miss Alicandri is a graduate of Kings County Hospital School of Nursing, Brooklyn, and holds a B.S. degree in nursing education from New York University.

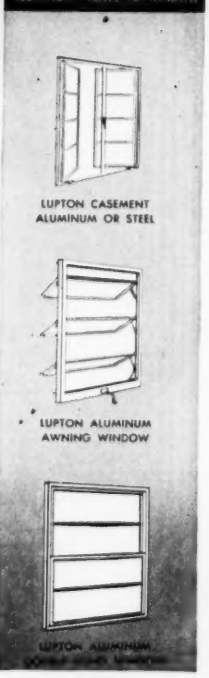
Kathryn M. Fugle, who has been nursing supervisor at Wyoming County Community Hospital, Warsaw, N.Y., since 1953, has been appointed director of nursing there, succeeding **Claire Bowman Mitchell,** who has resigned. Miss Fugle received a master's degree in hospital administration from Northwestern University, Evanston, Ill.

Flora Fulton, assistant director of nursing service at Grant Hospital, Chicago, has resigned to become director of nurses at Valley Children's Hospital, Fresno, Calif. Her appointment becomes effective September 1.



Mother House — Vincentian Sisters of Charity, Pittsburgh, Pa. Constructed by: Walter Butler Co. Saint Paul, Minn.





Built to last . . . with windows to match

In keeping with the dignity of an ancient order, this new building features sound, solid construction . . . to be as timeless as possible. And so do the windows . . . they are Lupton Aluminum Casements. Here is permanent beauty and permanent precision. Their operation through the years will never be hampered by clogging paint . . . Lupton Aluminum Windows will never need painting. They will always open easily and close snug and tight . . . as efficiently in the years to come as the day they were installed.

When you are thinking about windows, consider maintenance as well as initial cost. It is the year to year upkeep that determines the final price. Assure yourself of minimum maintenance with Lupton Aluminum Windows. Time will prove the wisdom of your choice. You'll have "lifetime" windows whose construction is the direct result of over 40 years experience in the designing and manufacturing of metal windows. Whatever the character of the building you plan, there is a Lupton Metal Window, in Steel or Aluminum, to complement it. Ask your architect to specify Lupton. Write direct for complete information.

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Miscellaneous

Richard Highsmith, administrator of Children's Hospital of the East Bay, Oakland, Calif., has been named executive vice president of that hospital. Mr. Highsmith is a graduate of the University of Cnicago's course in hospital administration and holds a B.S. degree in pharmacy. He has been assistant director of Evanston Hospital, Evanston, Ill., and of Oak Ridge Hospital, Oak Ridge, Tenn. Mr. Highsmith has been vice president and also treasurer of the Association of Western Hospitals and is a former president of the East Bay Hospital Conference. He is succeeded by **Harold Norman,** who was the former assistant administrator. Mr. Norman came to Children's Hospital as business manager and was later appointed administrative assistant. He is chairman of the economics section of the California Hospital Association.

Edwin L. Crosby, executive director of the American Hospital Association, Chicago, was awarded an honorary doctor of science degree by his alma mater, Union College, Schenectady, N.Y., at the college's recent commencement exercises. Dr. Crosby, long associated with Johns Hopkins Hospital, became director of the hospital in 1946. He resigned his position with Johns Hopkins in 1952 to become the first director of the Joint Commission on Accreditation of Hospitals. Dr. Crosby is a former president of the Baltimore Hospital Conference and of the Maryland - District of Columbia - Delaware Hospital Association.

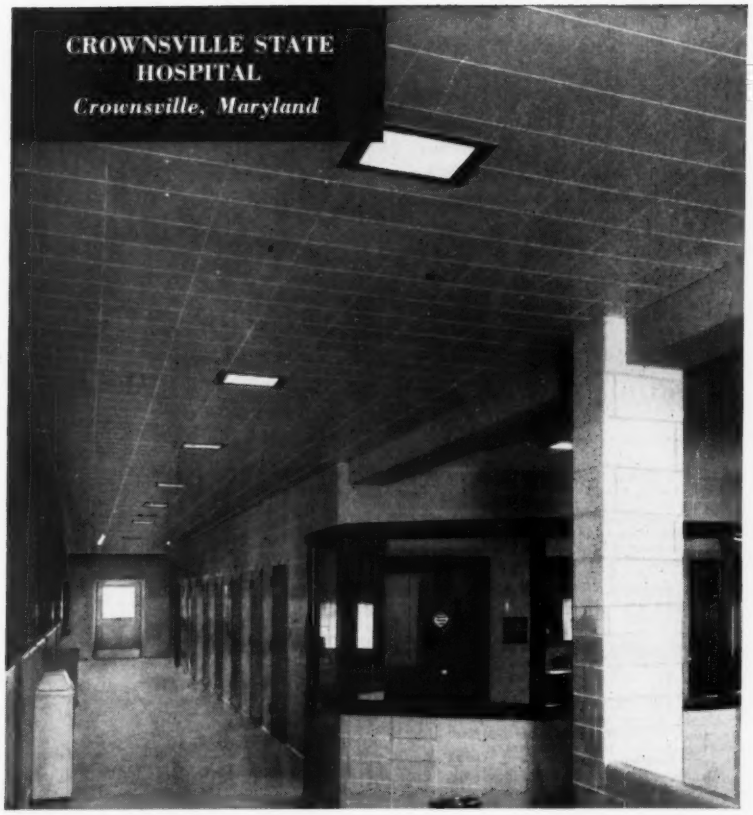
Dr. F. H. Arestad, associate secretary of the Council on Medical Education and Hospitals of the American Medical Association, has become medical administrator for the area office of the United Mine Workers Welfare and Retirement Fund in Johnstown, Pa. Dr. Arestad, who received his M.D. degree from the University of Minnesota, has served in the U.S. Medical Corps, and as medical consultant for the War Manpower Commission and National Nursing Council for War Service. He succeeds **Dr. Paul H. Streit,** who will be associated with the headquarters office of the fund.

J. Russell Clark, director of Brooklyn Hospital, Brooklyn, N.Y., was named president of the hospital association of New York State at the recent annual Middle Atlantic Hospital Assembly.

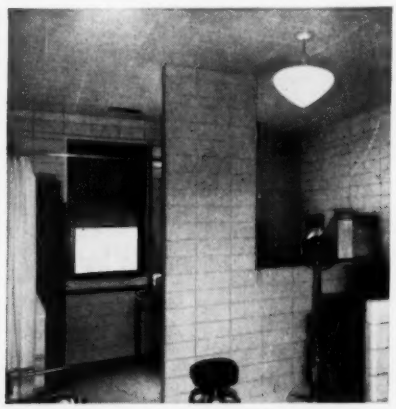
Daniel J. Shea, who has been assistant administrative secretary of the New York State Department of Mental Hygiene for the last two years, has been appointed senior administrative assistant of the department. Mr. Shea joined the department as director of personnel in 1945. He received his master's and doctor's degrees in education and psychology from Fordham University, New York.

Mrs. Ludel B. Sauvageot, director of public relations, Peoples Hospital, Akron, Ohio, has been named secretary of the International Council of Industrial Editors. Mrs. Sauvageot has been a member of the I.C.I.E. executive board for the last four years. The council is composed of 3500 editors of company publications throughout the United States, Canada, Hawaii and Europe.

Frank P. Sauer, administrator of Muhlenberg Hospital, Plainfield, **Robert G. Boyd,** administrator of Morristown Memorial Hospital, Morristown, and president of the Hospital Service Plan Association, and **I. Ellis Behrman,** administrator of Newark Beth Israel Hospital, all in New Jersey, have been



Architect: The Office of James R. Edmunds, Jr.
Acoustical Contractor: E. L. Stebbing Co., Inc.



Sanitary conditions in the hospital beauty parlor are kept high by this easy-to-clean ceiling of Arrestone. Its baked-on enamel finish can be washed or repainted whenever necessary without loss of acoustical efficiency.

Extra fire-safety is a valuable feature for any hospital. Arrestone's metal-pan construction is completely fireproof, will not help the spread of flame in this comfortable waiting-room area.

Efficient quiet for the busy nurses' station is provided by the noise-muffling Arrestone ceiling. Used to sound condition the whole hospital, Arrestone is one of the most efficient acoustical materials available.

Maintenance cut by sound-absorbing ceilings

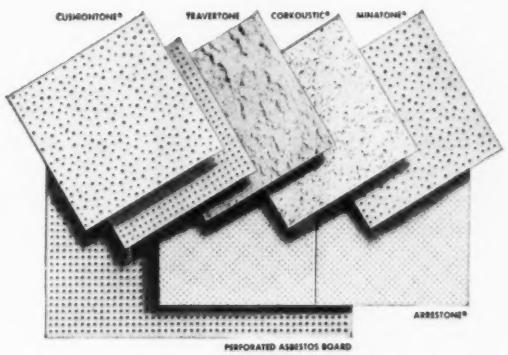
The need to maintain highest sanitary standards with the lowest possible maintenance expense poses a constant problem for all hospitals. In the new Admissions Building of the Crownsville State Hospital, architect Edmunds minimized the problem by installing acoustical ceilings of Armstrong's Arrestone.

Used throughout the building, Arrestone's easy, economical upkeep, plus its excellent noise-muffling characteristics, gives this material a twofold advantage.

A perforated metal-pan sound conditioner, Arrestone has a smooth, white enamel finish that's baked on for longer wear. This surface can be kept clean and new looking with only an occasional washing or repainting. Arrestone soaks up as much as 85% of the noise that strikes its surface.

Installed by mechanical suspension, sections of an Arrestone ceiling can be readily removed to facilitate repairs on concealed wiring and piping. Because fire-safety is important to hospital construction, Arrestone's incombustibility is another excellent reason for its choice in this building.

Get full details on Arrestone and Armstrong's other sound-conditioning materials from your local Armstrong Acoustical Contractor. For the free booklet, "How to Select an Acoustical Material," write Armstrong Cork Company, 4207 Union Street, Lancaster, Pennsylvania.



ARMSTRONG'S ACOUSTICAL MATERIALS

named to the board of the Hospital Service Plan of New Jersey.

Deaths

Dr. Fred W. Rankin, authority on cancer of the colon and abdominal surgeon in New York, died recently at the age of 67 after an illness of several months. Dr. Rankin had been president of the American College of Surgeons, the American Medical Association, and the American Surgical Association.

COMING EVENTS

AMERICAN ASSOCIATION OF BLOOD BANKS, Shoreham Hotel, Washington, D.C., Sept. 13-15.

AMERICAN ASSOCIATION OF HOSPITAL ACCOUNTANTS, Annual Institute on Hospital Accounting, Indiana School of Business, Bloomington, July 18-23.

AMERICAN ASSOCIATION OF MEDICAL RECORD LIBRARIANS, Sheraton-Cadillac Hotel, Detroit, Oct. 4-8.

AMERICAN ASSOCIATION OF NURSING HOMES, Annual Convention, Seelbach Hotel, Louisville, Ky., Oct. 18-20.

AMERICAN COLLEGE OF HOSPITAL ADMINISTRATORS, Annual Meeting, Palmer House, Chicago, Sept. 11-13. ***Institutes for Hospital Administrators:*** 6th Western Institute, Stanford University, Palo Alto, Calif., Aug. 2-13; 22d Chicago Institute, University of Chicago, Aug. 31-Sept. 10; 5th Chicago Advanced Institute, University of Chicago, Sept. 6-10; 9th Southern Institute, Richmond, Va., Nov. 1-5.

AMERICAN DIETETIC ASSOCIATION, Commercial Museum and Benjamin Franklin Hotel, Philadelphia, Oct. 26-29.

AMERICAN HOSPITAL ASSOCIATION, Navy Pier, Chicago, Sept. 13-16.

AMERICAN OCCUPATIONAL THERAPY ASSOCIATION, Shoreham Hotel, Washington, D.C., Oct. 16-22.

AMERICAN OSTEOPATHIC HOSPITAL ASSOCIATION, Annual Meeting, Hotel Baker, Dallas, Tex., Oct. 21-Nov. 3.

ARIZONA HOSPITAL ASSOCIATION, Hotel Westward Ho, Phoenix, Nov. 15-17.

CALIFORNIA HOSPITAL ASSOCIATION, Hotel Californian, Fresno, Oct. 28, 29.

ILLINOIS HOSPITAL ASSOCIATION, Hotel Abraham Lincoln, Springfield, Dec. 2, 3.

KANSAS HOSPITAL ASSOCIATION, Baker Hotel, Hutchinson, Nov. 11, 12.

MARYLAND-DISTRICT OF COLUMBIA-DELAWARE HOSPITAL ASSOCIATION, Spring Meeting, Hotel du Pont, Wilmington, Del., May 18; annual conference, Hotel Shoreham, Washington, D.C., Nov. 15, 16.

MISSISSIPPI HOSPITAL ASSOCIATION, 23d Annual Convention, Hotel Heidelberg, Jackson, Oct. 13-15.

MISSOURI HOSPITAL ASSOCIATION, Hotel Jefferson, St. Louis, Dec. 2, 3.

NEBRASKA HOSPITAL ASSOCIATION, Hotel Fontenelle, Omaha, Oct. 14, 15.

WASHINGTON STATE HOSPITAL ASSOCIATION, Chinook Hotel, Yakima, Sept. 29, 30.

1955

MASSACHUSETTS HOSPITAL ASSOCIATION, Annual Meeting, Hotel Statler, Boston, May 25.

OHIO HOSPITAL ASSOCIATION, Netherland Plaza Hotel, Cincinnati, March 7-10.

SOUTHEASTERN HOSPITAL CONFERENCE, Atlanta Biltmore Hotel, Atlanta, Ga. April 20-22.

WISCONSIN STATE HOSPITAL ASSOCIATION, Milwaukee, March 17.

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Standby Power Check Chart for Essential Services and Equipment

	Protected	Not Protected
• Operating Room	☐	☐
• Delivery Room	☐	☐
• Hall and Stair Lighting	☐	☐
• X-Ray Equipment	☐	☐
• Heating System	☐	☐
• Elevators	☐	☐
• Ventilation	☐	☐
• Communications	☐	☐
• Respirators	☐	☐

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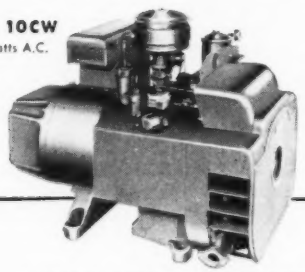

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If the check-chart above shows standby power for operating and delivery rooms *only*, your hospital may be inadequately protected. Interruption of *any* important hospital service because equipment can't be operated, may endanger lives. Property too may suffer damage.

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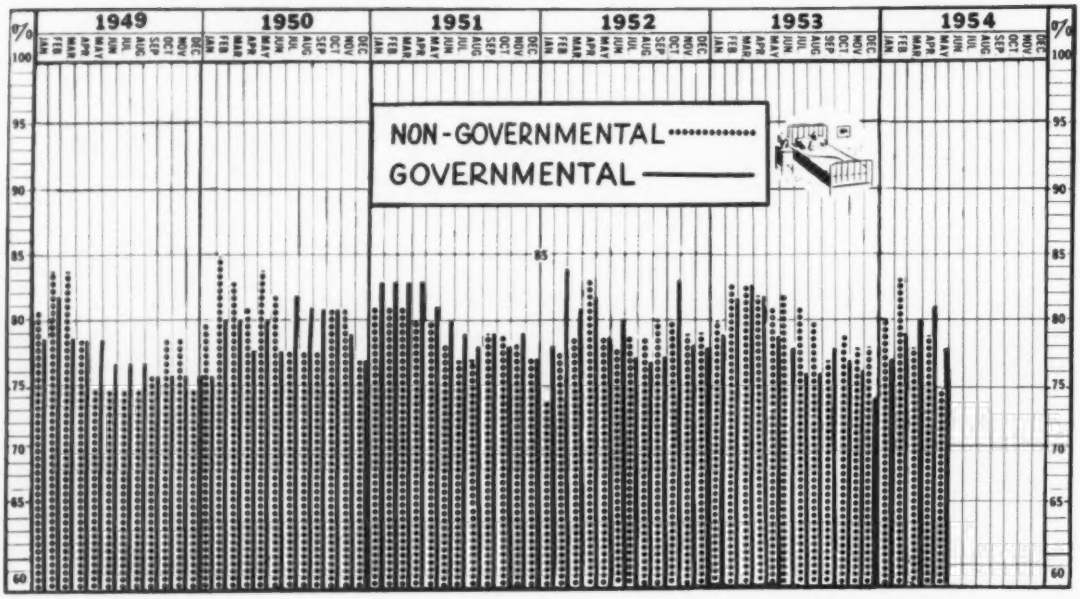
Voluntary Hospital Occupancy Is Declining



Government hospital reports to the Occupancy Chart show that for the month of May average daily occupancy was 77.9 per cent—0.1 per cent more than occupancy in May 1953. Non-government hospitals reported 74.6 per cent—a 5.3 per cent decline from a year ago.

For the latest period, May 17 through June 14, new hospital construction amounted to $44,244,290, bringing the year's total thus far to $227,324,542. Last year's figure of $34,024,665, for the corresponding period brought the year's total at that time to $339,103,889. The current 46 projects include 25 hospitals, 18 additions, and two nurses' homes.

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THE NEW BOOK PREPARED BY

AMERICA'S FOREMOST AUTHORITIES ON

HOSPITAL DESIGN AND ADMINISTRATION

DESIGN AND CONSTRUCTION OF GENERAL HOSPITALS

[a collaborative publishing effort of Architectural Record and The Modern Hospital to present the work of the U. S. Public Health Service]

The last ten years have witnessed such revolutionary progress in medical science that the very basic approach to the design of hospital buildings has been completely changed.

Expanded medical services, new diagnostic, surgical and therapeutic techniques have demanded an entirely new concept of hospital planning.

To meet this challenge, architects, hospital officials and public health authorities working together have evolved far-reaching improvements in design, equipment and facilities.

To examine, interpret, and report these momentous changes, the editorial staffs of two leading professional journals—ARCHITECTURAL RECORD and MODERN HOSPITAL—pooled their efforts with those of the Division of Hospital Facilities, U. S. Public Health Service and the fruits of this effort are contained in this comprehensive new book. This vast fund of planning information has never before been made available in one place.

"Design and Construction of General Hospitals" presents prototypes of successful hospital design, complete with 30 master plans for hospitals of every size. Each plan is accurately scaled, fully detailed, and visualized in a skillful rendering. Illustrations of floor plans, site plans, and a variety of charts and tabular data help to provide step-by-step guidance in the planning—from early sketches to completed buildings—of a modern hospital that truly suits the needs of today's most scientific therapy.

This authoritative volume is certain to win regard as the standard reference work on hospital planning for years to come. It is a source of information and planning data that neither hospital administrators nor hospital architects can afford to ignore.

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- Topography
- Landscaping

B. The Building
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- Traffic: Interior

C. Circulation Space
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- Stairways
- Elevators

III. ELEMENTS OF THE GENERAL HOSPITAL

A. Main Lobby
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- Director of Nurses' Office
- Medical Record Room
- Library & Conference Room
- Staff Lounge and Locker Room
- Gift Shop
- Personal Toilets

B. Nursing Facilities
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- Nurses Station
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- Utility Room
- Floor Pantry

C. Surgical Facilities
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- Scrub-up Facilities
- Clean-up Room
- Anesthesia Equipment Room
- Cystoscopic Room
- Fracture Room (Orthopedic)
- Laboratory
- Darkroom
- Instrument Room
- Surgical Supervisor's Office
- Doctor's Locker Room
- Nurses' Locker Room
- Closets
- Corridor
- Central Supply Facilities

D. Obstetrical Facilities
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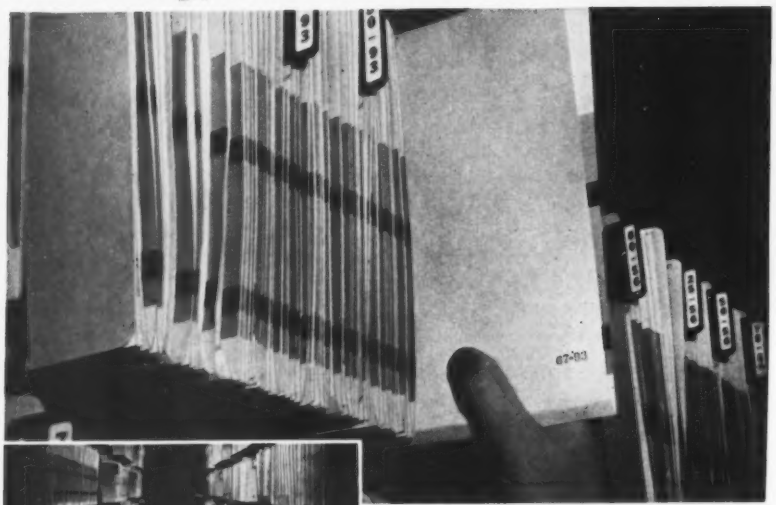

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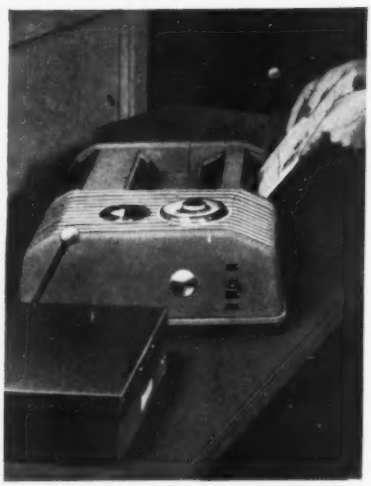

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ADMINISTRATOR—M.B.A.; Hospital Administration; administrative residency, three years, assistant administrator, large teaching hospital; six years, director, 300-bed general hospital.

ADMINISTRATOR—Master's; Hospital Administration; year's administrative residency, large public hospital; now completing residency, voluntary general hospital.

ANESTHESIOLOGIST—Diplomate; eight years, private practice, on faculty, medical school.

COMPTROLLER—B.A; Wisconsin; four years, accountant, three years, comptroller 300-bed hospital.

DIRECTOR OF NURSING—M.A., Major; Administration; four years' teaching; five years, director of nursing, 250-bed hospital.

PATHOLOGIST—Diplomate; M.S., Pathology; two years, associate pathologist, large hospital.

PERSONNEL DIRECTOR—A.B; considerable work toward MBA; personnel management; six years' personnel experience.

RADIOLOGIST—Diplomate; M.S., Radiology; four years, associate radiologist, large teaching hospital, on faculty medical school.

ADMINISTRATORS—Lay; B.A., Sociology; M.S., Hospital Administration; year's administrative residency; 1 year assistant administrator, general voluntary hospital 100-beds; 3 years, administrator, general hospital, 50-beds; seeks director, hospitals, 100-200 beds or assistant administrator, larger hospital under outstanding man; member ACHA; middle 30's.

ADMINISTRATOR—Lay; B.S., M.A., Education; M.S., Hospital Administration; 6 years, principal, high school; 1 year, administrative resident, 500-bed hospital; seeks directorship, hospitals, 100-300 beds.

ADMINISTRATOR—Medical; B.S., M.D., University Vermont; M.S., Hospital Administration; 5 years, administrator, university hospital 400-beds; member, ACHA.

ADMINISTRATOR—Registered nurse; male; M.S. Hospital Administration, Northwestern; 3 years director, blood bank, Bellevue; 5 years, administrator and supply officer, U. S. Army; 1 year, administrative resident and 5 years, assistant superintendent, general voluntary hospital 200-beds; seeks directorship small hospital or assistantship 300-beds up; requires warm dry climate account son's illness; member, ACHA.

ADMINISTRATOR—Lay; assistant; 30; B.S., Business Administrator, Cornell; M.S. Hospital Administration, Northwestern; 1 year, administrative residency, university hospital; 5 years, assistant to executive secretary, very important hospital council; seeks administrator assistantship, voluntary general hospital 200-beds up.

ANESTHESIOLOGIST—30; class A graduate; trained university hospital and medical center; 4 years Board credit; past year, anesthesiologist hospital group; prefer South Atlantic or east; seeks anesthesiologist group.

COMPTROLLER—32; B.S.; Accounting; past 3 years, business manager, university hospital 600-beds; seeks appointment as comptroller, hospital 200-300 beds or assistant comptroller and office manager in larger hospital; member American Association hospital accountants.

DIRECTOR OF NURSES; B.A.; 6 years, supervisor and instructor, voluntary general hospital 500-beds; 3 years, psychiatric supervisor, teaching hospital, 400-beds; early 40's; single.

PATHOLOGIST—30; finishing 2 years naval tour; M.D., Medical College of Virginia; Diplomate, clinical; taking Anatomy Boards; excellent residency in pathology and surgery; 2 years, chief, pathology, large naval hospital.

PURCHASING AGENT—Woman; 29; single; 10 years, assistant purchasing agent university hospital 500-beds; seeks position as purchasing agent smaller hospital or assistant purchasing agent larger hospital; prefer midwest.

RADIOLOGIST—39; Diplomate; diagnostic and therapy; trained university hospital; past 4 years, chief, radiology, 200-bed hospital; seeks larger hospital; will teach, prefer east of Mississippi; Virginia; Georgia.

(Continued on page 190)

WOODWARD—*Continued*

RADIOLOGIST—36; Diplomate; diagnostic and therapeutic; 3 years; chief, radiologist, important group distinguished men; past year, radiologist, 400-bed hospital; teaching post graduate in isotopes; prefer west or midwest.

SCIENCE INSTRUCTOR—38; B.S., single; 8 years, science instructor, 2 large hospitals; wishes position with more teaching, less nursing, near university; New Jersey; New York.

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EXECUTIVE HOUSEKEEPER—Age 48; course, institutional management; 8 years manager, small southern hospital; past 4 years executive housekeeper, 350 bed mid-western hospital; available September.

ADMINISTRATOR—F.A.C.H.A. 20 years experience, three eastern hospitals; interested in re-organizational programs.

ASSISTANT ADMINISTRATOR—B.S. Degree, Western Reserve University; completed 2 year course, hospital administration; residency, 400-bed eastern hospital.

BUSINESS MANAGER—B.S. Degree, Business Administration, Ohio State University, 1947; M.H.A. Degree, 1949; previous accounting experience; 5 years director, 100 bed midwestern hospital; desires change.

NURSE SUPERINTENDENT—15 years successful experience, 40-85 bed hospitals; recommended as outstanding administrator; any locality; free fall 1954.

PURCHASING AGENT—Degree in accounting; 15 years experience, 2 well-known eastern hospitals.

POSITIONS OPEN

ADMINISTRATOR—Competent hospital administrator, with hospital experience, for general hospital of 265-beds; municipally owned; applications close July 15, 1954; for application forms, apply to M. D. Stewart, Secretary, Sarnia General Hospital, Sarnia, Ontario, Canada.

ANESTHETIST—Registered nurse; New 250-bed, well equipped general hospital; department directed by medical anesthesiologist; cooperative medical staff and personnel; good personnel policies; salary depends on experience, minimum $414.00 with periodic merit raises. Apply, Director, McLaren General Hospital, 401 Ballenger Highway, Flint 2, Michigan.

ANESTHETIST—Nurse; 250-bed general hospital; salary $375.00-$425.00; full maintenance, vacation, sick leave, etc. Apply, The Ohio Valley Hospital, Steubenville, Ohio.

ANESTHETIST—Nurse; wanted for small private general hospital and clinic on Florida's gulf coast; rapidly growing community, nice place to live; staff of six with Board Surgeon, Board Obstetrician, Gynecologist; salary $400 monthly with meals, hospital insurance, two weeks vacation with full pay; complete references required. Apply, Adams Hospital, Inc., Panama City, Florida.

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POSITIONS OPEN

ANESTHETIST—Nurse; Lutheran Hospital; 200-beds; 3 nurse anesthetists directed by anesthesiologist; starting salary $350.00 per month; paid vacation, holidays, sick leave, etc. Apply, Gundersen Clinic, La Crosse, Wisconsin.

ANESTHETIST—Nurse; for 250-bed general hospital; excellent working conditions and personnel policies; good starting salary. Write: Mr. Bert Stajich, Assistant Administrator, Columbia Hospital, 3321 North Maryland Avenue, Milwaukee 11, Wisconsin.

ANESTHETISTS—Nurse; for 150-bed general hospital; four nurses, full-time M.D., all agents and techniques; one month's vacation; two and one-half hours from Boston and New York. Write, G. J. Carroll, M.D., Chief of Anesthesia Department, William W. Backus Hospital, Norwich, Connecticut.

DIETITIAN—Chief; A.D.A. member; 160-bed general hospital; good personnel policies. Frederick Memorial Hospital, Frederick, Maryland.

DIETITIAN—Teaching; A.D.A.; 329-bed hospital, 150 student nurses; previous hospital and teaching experience desirable; 40-hour week; paid vacation and sick leave; social security; salary open. Apply: Deaconess Hospital, Buffalo 8, New York.

DIETITIAN—Required for 67-bed general hospital; good salary, favorable personnel policies. Apply, stating experience, to Superintendent, Portage la Prairie General Hospital, Portage la Prairie, Manitoba, Canada.

DIETITIAN—For modern 75-bed hospital located in suburb of Montreal on Lake St. Louis; full maintenance provided. Apply, Administrator, Lachine General Hospital, Lachine, Quebec, Canada.

DIETITIANS—Therapeutic dietitians; Barnes Hospital, large teaching hospital; 3 units affiliated with Washington University School of Medicine; beginning salary $270 month; social security. Apply, Director of Dietetics. Barnes Hospital, 600 South Kingshighway, St. Louis 10, Missouri.

DIETITIANS—Staff; The New Miami Valley Hospital, Dayton, Ohio; the city beautiful; population 250,000; fine new 600-bed hospital with completely modern and up-to-date dietary facilities, has openings for staff dietitians; recognized educational program; 40-hour week; liberal personnel benefits; salary open, depending upon experience and background. Apply, Mrs. Vivian Laird, Chief Dietitian, Miami Valley Hospital, Dayton 9, Ohio.

DIETARY SERVICES—Director; applications are invited for this position, for a 500-bed medical teaching hospital; high administrative qualifications and broad knowledge required to the end that the most suitable system of food distribution can be incorporated in present major building program; salary open. Address applications to the Superintendent's Office, Kingston General Hospital, Kingston, Ontario, Canada.

DIRECTOR OF NURSING EDUCATION—B.S., capable of organizing and conducting a school of practical nursing; salary open; 40-hour week. Apply, Mrs. Marion G. Lamy, Superintendent, Moore General Hospital, Grasmere, New Hampshire.

DIRECTOR OF NURSING SERVICE—280-bed fully approved general hospital; must be qualified by preparation and experience; Degree required; full maintenance in comfortable living quarters; 40-hour week, salary open pending type of professional background; position available immediately. Apply, Administrator, Chester Hospital, Chester, Pa.

EDUCATIONAL DIRECTOR — 200-student school, affiliated with Drake University; 400-bed, fully approved, non-profit hospital, includes 115-bed pediatric unit; desire person with M.S. Degree in nursing education, will accept B.S. with successful experience; work with select, enthusiastic, stable student body with predominately rural backgrounds; salary open, 40-hour work week, 22 working days vacation, sick benefits; position available immediately. Apply, Director of Nursing, Iowa Methodist Hospital, Des Moines, Iowa.

(Continued on page 192)

Super Safety Cleaner

MULTI-CLEAN *Method*

with **ACTIVATED** **HCP**

What is HCP? HCP is the new activated chemical additive in Super Safety Cleaner that generates *higher cleaning power*. Developed by Multi-Clean chemists for fast, safe cleaning of all types of floors, the HCP additive powerizes the cocoanut oil action instantly—freeing dirt and holding it in suspension. Dirt floats away with wet pickup vacuum cleaner, floor squeegee or mop.

HCP helps free dirt and grime from floors almost instantly.

HCP helps hold dirt and grime in liquid suspension for easy removal.

HCP is completely safe for all types of floors.

CLEANS ALL FLOORS *FAST!* SAFELY!

Super Safety Cleaner, with HCP added, gets rid of floor dirt *fast*. But not at the risk of floor damage. **Super Safety Cleaner is *safe*.** Field tests have proved it is harmless to asphalt tile, rubber tile, linoleum, terrazzo, concrete, wood, magnesite and all other types of floors. **Super Safety Cleaner is *economical*.** Because of its high concentration, it goes more than twice as far as ordinary cleaners. Just 1½ ounces added to a gallon of water, even hard or cold water, will do almost all cleaning jobs *fast*. For fast removal of heavier wax build-ups, 8 ounces of Cleaner per gallon of water is recommended.

We Guarantee that Super Safety Cleaner, with HCP added, has been formulated from the finest ingredients under strict quality control, and when used according to directions *must* give satisfactory results.

Super Safety Cleaner with HCP is also available with germicide antiseptic added which eliminates odors and kills harmful bacteria or fungus organisms.

FREE TEST

See for yourself how Super Safety Cleaner with HCP will clean your floors. If you wish, a Multi-Clean distributor will be happy to make the test for you.

Send coupon for your free test. Send it Now! . . . no obligation.

MAIL THIS COUPON TODAY!

MULTI-CLEAN PRODUCTS, INC.
2277 Ford Parkway, Dept. ~~MH-7~~, St. Paul 1, Minnesota.

Gentlemen: Sure, I'd like a free test for my floors and more information on Super Safety Cleaner with HCP. I understand this puts me under no obligation.

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*Address*_____

*City*_____ *Zone*____ *State*_____

classified advertising

POSITIONS OPEN

HOUSEKEEPER—Executive; Evanston Hospital, Evanston, Illinois; applicants should write to the Administrator giving full details regarding training and experience.

INSTRUCTOR—Clinical; teach medical and surgical nursing; approved school in 224-bed general hospital; one class admitted annually; qualifications—B.S. Degree, 2 years teaching experience or equivalent; excellent salary; regular increases; 40-hour week; vacations; sick leave. Write, Director of Nursing, St. Luke's Hospital, Newburgh, New York.

INSTRUCTOR—Clinical; surgical 295-bed general hospital; Degree required, experience desirable; 40-hour week, good personnel policies, salary commensurate with preparation and qualification of applicant. Apply, Director, School of Nursing, St. Luke's Methodist Hospital, Cedar Rapids, Iowa.

INSTRUCTOR—Science; teach anatomy and physiology, chemistry and microbiology; approved school in 224-bed general hospital; one class admitted annually; qualifications—B.S. Degree, 2 years teaching experience or equivalent; excellent salary; regular increases; 40-hour week; vacations; sick leave. Write, Director of Nursing, St. Luke's Hospital, Newburgh, New York.

INSTRUCTORS — Nursing arts and science; for fall term 1954; progressive 200-bed hospital; approved school of nursing; admit one class yearly; beginning tremendous expansion program in school; degree and experience desired; excellent salary commensurate with qualifications and experience; transportation paid for interview of desirable applicants. For information, write: Mrs. Rita H. Smith, Director of Nurses, The McLeod Infirmary, Florence, South Carolina.

INSTRUCTOR—Nursing arts; school of nursing; 60 students; 125-bed hospital; for further information. Apply, Director of Nursing, Children's Hospital, Winnipeg, Manitoba, Canada.

MEDICAL DIRECTOR — Salary $14,070, to $17,670 per year; opening for experienced doctor with two years as a director, assistant director or clinical director; career opportunities at Philadelphia General Hospital, associated with medical schools and teaching institutions; two years specialized residency or M.A., in Hospital Administration, eligible to practice medicine in Pennsylvania. Apply before August 2, 1954 to Civil Service Examination Room, 127 City Hall, Philadelphia 7, Pennsylvania.

MISCELLANEOUS—Supervisors (2), Obstetrical and Surgical, General Duty Nurses at once; 34-bed hospital; separate residence, single rooms; salary includes full maintenance. Apply, Superintendent, Ajax and Pickering General Hospital, Ajax, Ontario, Canada.

MISCELLANEOUS — Assistant director of nurses, Supervisors and Head nurses for 2200-bed psychiatric hospital; salary depends on experience and qualifications; additional Staff needed for Educational and Therapeutic programs. For particulars apply to Personnel Director, Central State Hospital, Indianapolis 22, Indiana.

NURSE—Head, nurseries; 60 bassinets; 225-bed general hospital, with new modern nurseries being planned; good salary to qualified person; 40-hour week. Apply, Director of Nursing, San Jose Hospital, San Jose, California.

NURSE—Head; delivery room; 332-bed general hospital with school of nursing; Degree and experience desired; 40-hour week, liberal personnel policies, living accommodations available, salary commensurate with qualifications; position available immediately. Apply, Director of Nursing, The Toledo Hospital, Toledo 6, Ohio.

NURSES—General staff; for 350-bed general hospital; no obstetrics; center city location; 40-hour week; 3 weeks vacation; $220 monthly base gross salary; $20 monthly increment for 3-11 and 11-7 tour of not less than one month; 50% discount on tuition rates for University of Pennsylvania matriculation. University of Pennsylvania Graduate Hospital, 1818 Lombard Street, Philadelphia 46, Pennsylvania.

(Continued on page 194)

classified advertising

POSITIONS OPEN

NURSE Registered; position in Maryland at Montrose School for Girls—white, delinquent; advantages of merit system employment offered; maintenance at cost; for complete information. Apply, Miss Frederick, Superintendent, Montrose School for Girls, Reisterstown, Maryland.

NURSES—General staff; 250-bed general hospital and 72-bed maternity hospital; starting salary $280; $5 per month tenure increase for each six months of service to a maximum of $310; social security, sick leave, prepaid medical and hospital care; $10 additional for afternoon and night shift; $10 additional for delivery room; $20 additional for surgery; up to three weeks' vacation at end of 4 years; 7 paid holidays; 8-hour day, 40-hour week. Apply to Director of Nurses, Sutter Hospital, Sacramento, California.

NURSES—Graduate; for new 50-bed general hospital in thriving village, Catskill Mountains; 8-hour day, 6-day week, time-and-one-half for overtime after 40 hours, rotating shifts; average gross cash salary $200 to $210 month; full maintenance available for $10.50 week. Apply, Superintendent Nurses, Margaretville Hospital, Margaretville, New York. Phone Margaretville 50.

NURSES—Graduate; positions open for two graduate nurses who either have, or are willing to obtain Colorado registry; floor duty, rotating shifts; starting salary $250.00 per month, 44-hour week; laundry furnished; under Social Security; two weeks paid vacation per year; high in the new Uranium country. Apply, MW 48, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

NURSES—Operating room; 300-bed hospital; 40-hour week; all cash salary; special consideration for experience and advance preparation; bonus for "on call"; liberal personnel policies, including social security, plus a retirement plan. Apply, Director of Nursing, Mercer Hospital, Trenton 8, New Jersey.

NURSES—Operating room and staff; 100-bed general hospital; salary $280 per month; 40-hour week; $10 differential afternoon, night, and surgery duty; annual vacation and raises; 7 paid holidays, sick leave and free hospitalization and insurance. Apply, Director of Nurses, Mercy Hospital, 4001 J. St., Sacramento, California.

NURSES—Operating room and obstetrical; California hospital on San Francisco Bay; forty minutes from that city; 5-day week; salary $275 per month if applicant has advanced preparation or experience; $10 additional for evening and night duty; maintenance available. Director of Nursing, Alameda Hospital, Alameda, California.

NURSES—Psychiatric; for a new psychiatric unit in a 700-bed hospital; excellent personnel policies. Write Mrs. Aileen L. Carroll, Director of Nursing, The Buffalo General Hospital, 100 High Street, Buffalo, New York.

NURSES—Registered; general duty nurses; $275.00 days, $285.00 P.M. and nights, $5.00 increase after 6 months, and every 6 months thereafter for 3 years; 40-hour week, paid vacation, sick leave and holidays. Apply, Pioneer Memorial Hospital, Prineville, Oregon.

PATHOLOGIST—To head department; approved hospital in Pennsylvania. Address reply to MO 80, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

PHYSICAL THERAPIST — Registered; 160-bed general hospital in town of 24,000; modern facilities; salary commensurate with experience; good personnel policies; Write, Administrator, Waukesha Memorial Hospital, 725 American Avenue, Waukesha, Wisconsin.

SUPERVISOR—Operating room nurse; wanted immediately for new surgical unit, 400-bed chest hospital, located outside of Buffalo, New York; maintenance available; starting annual salary for 48-hour week $4863; maximum after 5 years service $5867; liberal vacation and sick leave; State pension system. Apply, Director, J. N. Adam Memorial Hospital, Perrysburg, New York.

(Continued on page 196)

classified advertising

POSITIONS OPEN

TECHNICIAN—Laboratory; registered; 150-bed general hospital; three technicians under supervision pathologist. Write, Administrator, Yakima Valley Memorial Hospital, Yakima, Washington.

SUPERVISORS — Operating room supervisor and Assistant supervisor; salary open; complete maintenance if desired. Shriners' Hospital for Crippled Children, Philadelphia 15, Pennsylvania. MA 4-0700.

SUPERVISOR—Administrative, operating room; 225-bed general hospital, with new modern surgeries being planned to meet immediate expansion program; top salary to qualified person; 40-hour week. Apply, Director of Nursing, San Jose Hospital, San Jose, California.

SUPERVISOR—Pediatric; for medical and surgical units in 100-bed children's hospital; must have experience and special training in pediatrics; personnel policies as recommended by state nurse association; quarters available. Apply, Director of Nursing, Babies Hospital-Coit Memorial, Newark, New Jersey.

The Medical Bureau

M. BURNEICE LARSON—DIRECTOR

Telephone DElaware 7-1050

PALMOLIVE BUILDING CHICAGO

ADMINISTRATORS — (a) Medical director; large teaching hospital; medical center, midwest. (b) Medical; 600-bed general hospital currently under construction; affiliated medical school; west. (c) Voluntary general hospital, 400-beds; expansion program increasing service facilities; Pacific coast. (d) General hospital, 280-beds; expansion program will add 100-beds within year; $18,000; east. (e) General hospital, medium bed capacity, fully approved; California. (f) To succeed administrator resigning after long tenure; 100-bed general hospital; resort city, east. (g) Assistant, minimum three years' administrative experience; accounting background required; 250-bed general hospital; $7500-$8000. (h) Assistant; new 300-bed hospital; recent graduate qualified take charge purchasing; college town, southwest. MH7—1

ADMINISTRATORS — WOMEN. (a) Small general hospital; university town, California. (b) New hospital, 100 beds serving rehabilitation center; east. (c) Assistant; 400-bed general hospital; large city, medical center, midwest. MH7—2

(Continued on page 198)

MEDICAL BUREAU—*Continued*

ANESTHETISTS—(a) Clinic staffed by sixteen specialists; residential town, near several large cities; midwest; $7200. (b) Chief; new hospital, 200-beds; resort town, North Carolina. (c) General hospital, 500 beds; residential town vicinity New York City. (d) Voluntary general hospital, 500-beds; interesting city outside United States. (e) By oral surgeon; California. MH7—3

COLLEGE, CLINIC—(a) State college, south. (b) Clinic; 15-man group; midwest. (c) School for girls; beautiful campus overlooking Pacific Ocean. MH7—4

DIETITIANS—(a) Chief; new hospital, 150 beds, affiliated medical school; south. (b) Nutrition advisor; medical department, industrial company; east. (c) Several dietitians to teach and counsel patients at medical school clinics; large city, midwest. (d) Chief; university hospital, 300 beds; plans completed for new medical center including hospital of considerably greater capacity. (e) Chief, associate, teaching and therapeutic dietitians; large general hospital; Canada. MH7—5

DIRECTORS OF NURSES—(a) Dean, school operated by college, under its exclusive control; Pacific coast. (b) New general hospital, 350 beds affiliated group staffed by 25 American Board specialists; suburban location, east. (c) Large general hospital affiliated medical school; midwest. (d) South America; degrees, knowledge Spanish, French or Portuguese required.

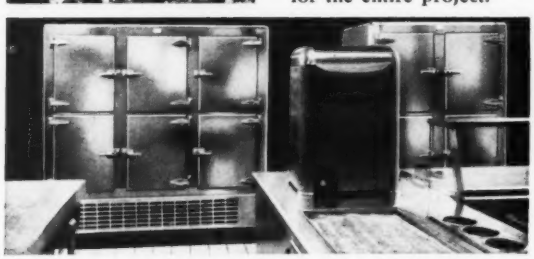
HERRICK

STAINLESS STEEL REFRIGERATORS

Performance-Proved

at *Neiman-Marcus* Dallas, Texas

Left: Exterior view of the Neiman-Marcus downtown specialty store. A recent $7,500,000 expansion program included doubling the space of this store, adding a new $2,000,000 suburban store and a new $1,000,000 service building to serve the two units. DeWitt and Swank of Dallas were the architects for the entire project.



Above: Part of the kitchen which serves the "Zodiac" Restaurant and two employee restaurants in the main store. Shown left to right . . . are HERRICK Models SP60B (6-door) and SP33B 4-door).

Right: A close-up of HERRICK Model SP33B in the Neiman-Marcus kitchen. HERRICK units for this kitchen were supplied by Huey and Philp, Dallas.

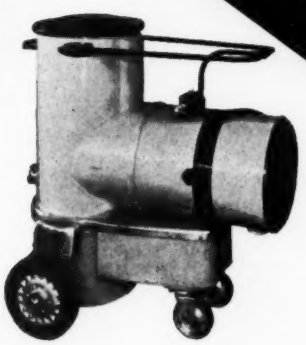
From a small, two-story building in 1907, Neiman-Marcus has grown to be one of the largest retail distributors of fine merchandise in the world. Pride of the southwest, this forward-looking organization has always pioneered in progressive merchandising. Neiman-Marcus *sells* the best . . . Neiman-Marcus *buys* the best. That's why they selected HERRICK Stainless Steel Refrigerators for the modern kitchen that services their smart, new "Zodiac" restaurant . . . as well as two employee restaurants. • When HERRICK Stainless Steel Refrigerators are on the job, foods are always kept at peak freshness and flavor. HERRICK'S complete food conditioning provides the ultimate in trouble-free refrigeration. For greater dollar value, buy HERRICK. Write today for the name of your nearest HERRICK supplier.

HERRICK REFRIGERATOR CO., WATERLOO, IOWA
DEPT. M., COMMERCIAL REFRIGERATION DIVISION

HERRICK *The Aristocrat of Refrigerators*

HOSPITAL QUIET FOR HOSPITAL USE

SILENT
MODEL P125



Designed for hospitals, the Spencer Silent Portable Vacuum Cleaner is so effectively muffled that patients are not aware it is running. Rubber-tired to get there quietly, equally efficient for wet or dry pick-up, and the cleaning of any kind of surface. Special attachments for cleaning dry mops. Send for 32-page booklet.

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POSITIONS OPEN

MEDICAL BUREAU—*Continued*

(e) Nursing service only; important hospital; California. (f) Nursing service; general hospital, 300 beds; residential town near New York City. MH7—6

EXECUTIVE HOUSEKEEPER—400-bed teaching hospital, four residences; university city, midwest. MH7—7

EXECUTIVE PERSONNEL—(a) Personnel director, 200-bed general hospital expanding to 400; industrial city, Rocky Mountains. (b) Comptroller; 550-bed general hospital; degree, minimum five years' experience; $8,000; midwest. (c) Purchasing director; extensive experience on administrative level required; large teaching hospital; east. (d) Personnel director qualified public relations; 350-bed hospital; midwest. MH7—8

FACULTY APPOINTMENTS—(a) Assistant director of nursing in charge of nursing education and clinical instructors in obstetrics, pediatrics, psychiatry; voluntary general hospital, 450-beds; expansion program; 160 students; attractive location outside United States. (b) Assistant dean and assistant professor of nursing; west. (c) Educational directors and instructors; South America; knowledge Spanish, French or Portuguese required. (d) Public health nursing instructor; university nursing department; east. (e) Medical and surgical instructor; collegiate school; California. (f) Nursing arts instructor; college of nursing, organized on same basis as other five colleges of university; south. (g) Science instructor; 300-bed hospital affiliated medical school; university city, Pacific coast. MH7—9

MEDICAL RECORD LIBRARIANS—(a) Chief; medical school teaching hospital; staff of 10; university city, west. (b) Chief; new general hospital, 800 beds affiliated medical center; south. (c) Chief; large general hospital; university city, New England; minimum $4800. MH7—10

SUPERVISORS—(a) Operating room and pediatric; large teaching hospital; Pacific coast. (b) Obstetrical; 68-bed department, 475-bed general hospital; suburb, large city, east; minimum $4000. (c) Pediatric; large teaching hospital; university medical center, midwest; $4800-$5400. (d) Surgical; small general hospital; outside United States; pleasant climate; $5000. (e) Administrative supervisor in medical-surgical nursing; teaching hospital, 250-beds; expansion program; university city, midwest. (f) Operating room and obstetrical; large general hospital; interesting city, outside United States. MH7—11

STAFF—(a) All departments; new hospital, recently completed; unit university group; opportunity continuing studies; west. (b) Plantation hospital and clinic; outside United States; although tropical, pleasant mild climate. (c) Staff and surgical; small general hospital; coastal town, Alaska. MH7—12

(Continued on page 200)

BUSINESS AND MEDICAL REGISTRY
(Agency)
Elsie Miller, Director
610 South Broadway, Room 1105
Los Angeles 14, California

DIRECTOR OF NURSES—Industrial company hospital, 25 beds, 16 patient average; supervision outpatient clinic also; should know surgical technique; staff includes 11 nurses, 7 doctors; cooperative group; $400 plus room and board, 40-hour week.

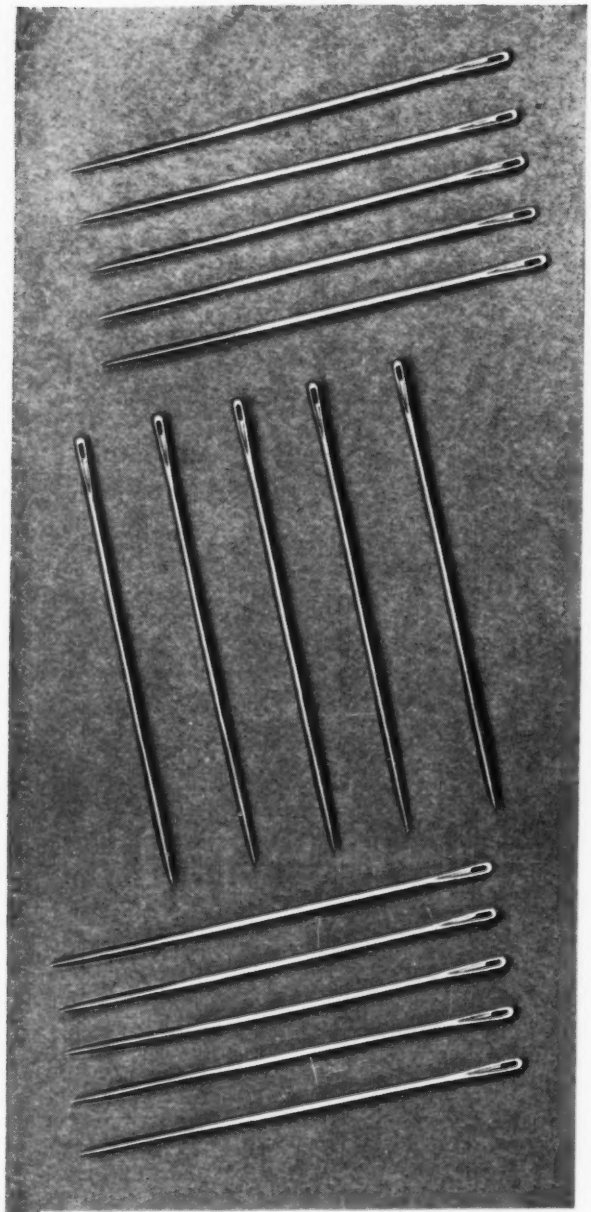
GENERAL DUTY—35-bed California hospital seeks 3 to 11 nurse; $15 per eight hours, may work 5 or 6 day week; room and meals furnished; $30 per month.

LABORATORY AND X-RAY TECHNICIANS—Two southern California clinics have openings; 5-day week, no call. $375-$400.

LABORATORY TECHNICIAN—Los Angeles internist offers $350 for five day week, Monday through Friday, no call.

DIETITIAN—College seeks dining hall manager to supervise food preparation, kitchen help and assist in menu planning for 500 resident students; $325-$415 plus two meals; 12 months' basis.

DIETITIANS—Several needed as managers of school lunch cafeterias in southern California; $375-$400 monthly; 10 months' basis; weekends and holidays always free.



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surgeons needles

Order from your hospital supply dealer. Catalog on request.

THE TORRINGTON COMPANY, Torrington, Conn.
Specialists in Needles since 1866

Here's <u>proof</u> that Bassick truck casters last longer

You get more for your money when you buy Bassick truck casters. This photo shows why.

Even a file can't cut the swivel bearing surfaces of these top-quality casters. They're *fully* case-hardened (to 15N90 Rockwell hardness). Special furnaces make sure the right degree of hardness is achieved.

This means you won't be plagued by premature wear or failure of these vital bearing parts when you install Bassick double ball bearing steel casters on service carts, laundry trucks and similar mobile equipment.

Series "99" truck caster

This tough steel caster has fully case-hardened bearing surfaces for longer wear. It's quiet, easy-rolling and easy-swivelling — best bet for institutional trucks. Sizes from 3 in. to 8 in.

Find out more about Bassick casters in the Hospital Purchasing File

THE BASSICK COMPANY, Bridgeport, 2, Conn. *In Canada:* Belleville, Ont.

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STEWART SW WARNER

MAKING MORE KINDS OF CASTERS...MAKING CASTERS DO MORE

75 YEARS OF CASTER LEADERSHIP

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POSITIONS OPEN

INDIANA MEDICAL BUREAU
212 Bankers Trust Building
Indianapolis, Indiana

ADMINISTRATORS—(a) Well qualified woman executive to assume responsibility for non-professional aspects of rehabilitation center, east. (b) Nurse-administrator, small hospital northwest; $350-$400. (c) High calibre man age 35-50 with proven record, 200 bed eastern hospital, to $18,000. (d) Business administrator, male, 40-bed Lutheran hospital; midwest.

LABORATORY TECHNICIANS—(a) Supervisor, large midwestern state mental hospital; college degree and two years experience $300-$450. (b) Chemist, midwestern city department of health; must have M.S.; serology, milk and water, dilution; minimum $400. (c) Chemist, state dept. of health, M.S., analytical work on drugs. (d) Small midwestern hospital, knowledge of x-ray; to $350.

RECORD LIBRARIANS—(a) Registered, for assistant, 162 bed northern hospital. (b) Registered, to set up department for 70 bed eastern hospital. (c) Registered, 650 midwestern university-affiliated hospital; $375 to $420.

INDIANA MEDICAL BUREAU
—Continued

MEDICAL SECRETARY—Psychiatry; 25-40; prefer some college or business training, shorthand and machine dictation, public relations, board contact; salary range $250-$300.

ADMINISTRATOR—(a) Lay or medical; man with demonstrated administrative ability; will meet financial requirements; university hospital 900-beds. (b) Medical; teaching hospital 800-beds; $20-$30,000; career post; nationally known man required. (c) Lay; voluntary general hospital 175-beds; newly opened; California. (d) Lay; voluntary general hospital 200-beds; $15-$18,000; east. (g) Medical; voluntary general hospital 300-beds; attractive university town 100,000; south. (h) Fairly new voluntary general hospital 100-beds; excellent board; university town; central. (i) Lay; voluntary general hospital 160-beds; town 60,000; resort area on Great Lakes. (j) Lay; general hospital 80-beds; excellent medical staff of 22; town 10,000; center of important recreational area; hunting-fishing; Pacific northwest. (l) Lay; assistant; general hospital 200-beds; opportunity to succeed present administrator short time; California. (m) Lay; assistant; general hospital 200-beds; teaching unit of important medical school large city; east.

ADMINISTRATORS — Women. (a) Nurse, well-qualified in anesthesia; voluntary general hospital 28-beds; about $7500; lovely residential town; southwest. (b) Nurse; general hospital 60-beds; residential town 35,000; west. (c) Voluntary general hospital 80-beds; liberal policies; California. (d) R.N.; voluntary general hospital 100-beds; $7-$10,000; east.

ADMINISTRATIVE EXECUTIVE PERSONNEL—(a) Business manager; children's hospital; West coast. (b) Business manager; group 14 specialists; long-established; modern clinic building; university city; California. (c) Comptroller; 550-bed hospital; full charge; substantial salary; town 150,000 midwest. (d) Personnel director; general voluntary hospital 500-beds; large city; east. (e) Purchasing agent; general voluntary hospital of large size; substantial salary depending on experience; California.

(Continued on page 202)

classified advertising

POSITIONS OPEN

SHAY MEDICAL AGENCY
Blanche L. Shay, Director
55 East Washington Street
Chicago 2, Illinois

ADMINISTRATORS—(a) South; 600-bed hospital, fully approved; require excellent background of experience in hospital administration. (b) South; 300-bed hospital located in large southern city. (c) Middle West; 60-bed hospital located in prosperous farming area; hospital is modern in all respects. (d) Assistant; East; 187-bed hospital located in city of about 75,000; good housing facilities; excellent opportunity for young man to work under a well qualified administrator. (e) Assistant; Middle West; will work as administrative director responsible to the executive director; require good educational background in hospital administration plus several years practical experience; this is an excellent opportunity; $10,000 to start.

COMPTROLLER—Middle West; 100-bed hospital located in city of about 35,000; 170 employees; there is an extensive building program under way and position offers excellent opportunity for advancement; $5000 to start.

BUSINESS MANAGERS—(a) East; 225-bed hospital; must have good background in accounting; assume full charge of business office. (b) Middle West; R.N. with experience in handling personnel and patients; privately owned clinic; $400 a month to start. (c) East; 25 man medical group with complete x-ray, medical laboratory, physical therapy, etc.; good accounting experience plus ability to handle personnel successfully; $6000.

EXECUTIVE HOUSEKEEPERS—(a) Middle West; 200-bed general hospital located in city of about 75,000; 40 employees in department; $5400. (b) South; 360-bed general hospital, fully approved located in beautiful southern city of about 70,000; $5400. (c) Pacific coast. 125-bed modern general hospital, fully approved; expansion program under way; located in lovely college town; 25 employees in department; $5400. (d) East; 400-bed general hospital; must have good supervisory experience; about 100 employees in department; $6000.

INTERSTATE MEDICAL PERSONNEL BUREAU
Miss Elsie Dey, Director
332 Bulkley Building
Cleveland, Ohio

EXECUTIVE HOUSEKEEPERS—(a) 150-bed hospital, Wisconsin. (b) 300-bed hospital, northern Illinois. (c) 275-bed hospital, Ohio; $400. (d) Residence manager, modern building; Ohio; $295. (e) Assistant housekeeper, 200-bed university city, mid-west.

ADMINISTRATORS—(a) 95-bed New Jersey hospital. (b) 60-bed Illinois hospital. (c) 150-bed Michigan hospital; re-organizational program. (d) 50-bed new modern Ohio hospital. (e) Small mid-western hospital; plans building 50-bed addition.

CONTROLLERS—(a) 450-bed mid-western hospital; $7500. (b) 300-bed hospital, New York state; $7000. (c) Assistant. 500-bed hospital; industrial city, east.

NURSE SUPERINTENDENTS—(a) 75-bed orthopedic hospital, mid-west. (b) 35-bed Massachusetts hospital; new. (c) 50-bed Ohio hospital. (d) 40-bed modern hospital, Iowa.

DIRECTORS, SCHOOL OF NURSING—(a) 340-bed hospital, Ohio. (b) Nurse co-ordinator, collegiate school; Middle-Atlantic state; $6,000. (c) 300-bed outstanding southern hospital; $6,000 maintenance. (d) Assistant director, western collegiate school.

DIRECTORS, NURSING SERVICE—(a) 185-bed hospital, New York state. (b) 165-bed hospital, Delaware. (c) Orthopedic hospitals, east and midwest. (d) 125-bed Ohio hospital; $500.

RECORD LIBRARIANS—East, midwest, south; to $400.

(Continued on page 204)

classified advertising

POSITIONS OPEN

INTERSTATE—*Continued*

TECHNICIANS laboratory — (a) 210-bed hospital, Ohio. (b) Chief x-ray; 250-bed hospital, midwest; $425. (c) Laboratory x-ray; southwest; Ohio, Indiana, Pennsylvania; to $350.

DIETITIANS chief — (a) 250-bed hospital, Pennsylvania; $5000. (b) Therapeutic; all localities; $300-$350.

PLACEMENT BUREAUS

THE MEDICAL FIELD
EMPLOYMENT AGENCY
790 Broad Street — cor. Market
Newark 2, N.J.
MItchell 2-1940, 1941

A MEDICAL AGENCY specializing in placements for Industry, Pharmaceutical Houses, Doctors' Offices and Institutional help.

Eleanor M. Mangini, R.N.
Director

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MARY A. JOHNSON ASSOCIATES
11 West 42 Street New York 36, N. Y.
Mary A. Johnson, Ph.D., Director

FINE SCREENING BRINGS BEST RESULTS

Our careful study of positions and applicants produces maximum efficiency in selection. Candidates know that their credentials are carefully evaluated to individual situations, and only those who qualify are recommended. Our proven method shields both employer and applicant from needless interviews. We do not advertise specific available positions. Since it is our policy to make every effort to select the best candidate for the position and the best job for the candidate, we prefer to keep our listings strictly confidential.

We do have many interesting openings for Administrators, Physicians, Anesthetists, Directors of Nurses, Dietitians, Medical Technicians, Therapists, and other supervisory personnel.

No registration fee
Agency

(Continued on page 206)

PLACEMENT BUREAUS

HOSPITAL PERSONNEL BUREAU
Charles J. Cotter, Director
(Licensed Employment Agent)
Professional Arts Bldg.
Hagerstown, Maryland
Telephones: Office—950; Res.—2885

Positions available, most areas. Administrators, Pathologists, Anesthetists, Pharmacists, Housekeepers, Technicians, Dietitians, Librarians, Directors of Nurses and all nursing positions. Send resumé, 10 snapshots, date available.

ZINSER PERSONNEL SERVICE
Anne V. Zinser, Director
Suite 1004—79 West Monroe Street
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We have many good openings for Directors of Nurses, Instructors, Supervisors, Dietitians, Medical Technicians, Record Librarians and Staff Nurses. If you are looking for a position, please write us.

classified advertising

PLACEMENT BUREAUS

BROWN'S MEDICAL BUREAU (Agency)
7 East 42nd Street
New York City 17

If you are seeking a position or personnel—please write. Gladys Brown, Owner-Director. We Do Not Charge a Registration Fee.

FOR SALE

NURSES! ORDER THE NEW SEALED EDGE KENMORE NURSE'S KIT, "Your Pocket Pal." Save uniforms, save laundry bills, save time. Made of white box calf with three divisions for pen, surgical scissors and thermometer; also coin purse. THE PERFECT GIFT! $1 Postpaid. $7.50 per dozen. 8718 Ashcroft Ave., Hollywood 48, Calif.

NURSING AND MEDICINE

We have in stock every nursing or medical book published. Lowest prices with unexcelled service. Write Chicago Medical Book Company, Jackson and Honore Streets, Chicago 12, Illinois.

FOR SALE

Burdick Infra Red Lamps, Zeolite 12-S. New. Government Surplus. 110/120 V. AC/DC. 475 Watt. Protective Screen. Booklet. $31.75. Order now. Quantity limited. CHEMICAL SERVICE CORP., 90-06 Beaver St., New York 5, N.Y.

New and used hospital equipment bought and sold. Large stock on hand for the physician, hospital and laboratory. Write for what you want or have for sale.

HARRY D. WELLS
400 East 59th Street, New York City

SCHOOLS—SPECIAL INSTRUCTION

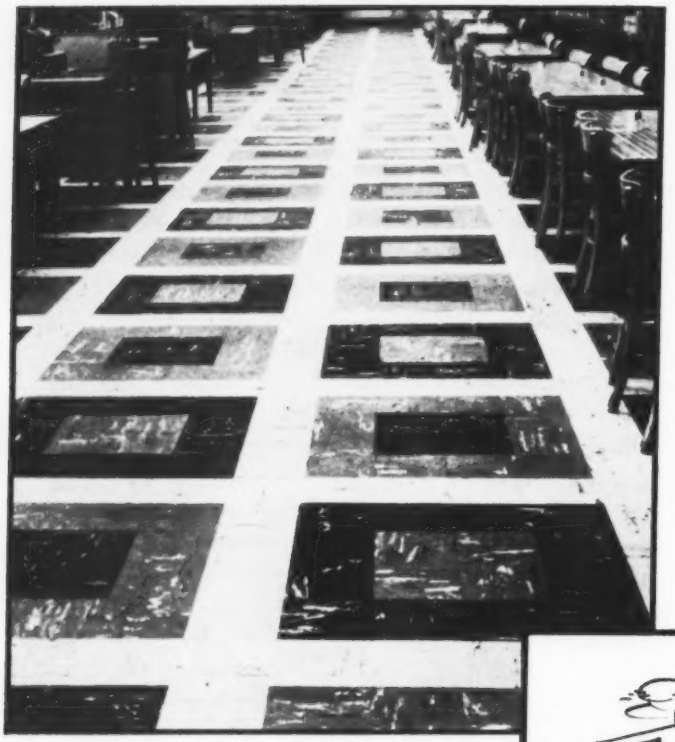
The PROVIDENCE LYING-IN HOSPITAL offers to qualified graduate nurses a four months supplementary clinical course in Obstetrics. Full maintenance and stipend of $60 a month provided. For full information, apply to the Director of Nurses, Providence Lying-In Hospital, Providence 8, Rhode Island.

SCHOOLS—SPECIAL INSTRUCTION

THE McLEOD INFIRMARY School of Anesthesia, approved by the American Association of Nurse Anesthetists. Open to registered nurses of accredited schools of nursing. For complete information and application blanks write to Everard R. Hicks, Director of the School of Anesthesia, Florence, South Carolina.

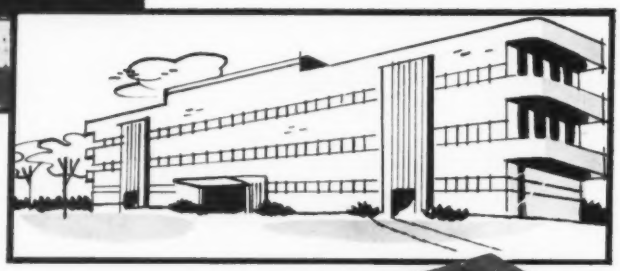
SCHOOL FOR LABORATORY TECHNICIANS—Duration of course, 1 year. Tuition, $100.00; approved by the American Medical Association. For further information, write the Director of Laboratories, Barnes Hospital, 600 S. Kingshighway, St. Louis, Missouri.

Selected for maximum wear with minimum care...



Johns-Manville TERRAFLEX Vinyl Floor Tile

...in one of the Sperry Gyroscope Co. employee cafeterias



Despite constant exposure to heavy traffic, spilled food, grease, and liquids, the Terraflex floor in the cafeteria of the Sperry Gyroscope Company at Lake Success, L. I. shows no sign of wear—looks as fresh and colorful as the day it was installed.

J-M Terraflex needs less care and gives longer wear than any other type of resilient flooring of equal thickness . . . pays for itself through years of low-cost maintenance

After exhaustive tests of many resilient type floors, the Sperry Gyroscope Company selected Johns-Manville Terraflex Vinyl Tile for the floor of one of its employee cafeterias.

J-M Terraflex® is a flooring of time-proved superiority. Made of vinyl and asbestos it is exceptionally tough and resistant to traffic . . . defies grease, oil, strong soaps and mild acids.

Terraflex saves time and dollars through low-cost maintenance. Its nonporous surface requires no hard scrubbing...damp mopping keeps it clean and bright . . . frequent waxing is eliminated. Through years of economical service Terraflex pays for itself.

Available in a large range of striking colors, Terraflex is ideal for restaurants, public areas, schools, hospitals.

Specify J-M Terraflex whenever your plans call for resilient flooring. Its long-wearing beauty and long-time economy provide a maximum of reliable floor service. For complete information write Johns-Manville, Box 158, New York 16, N. Y.

Johns-Manville

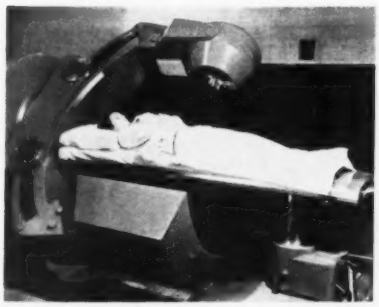
JOHNS-MANVILLE JM PRODUCTS

What's New for Hospitals

JULY 1954 — Edited by BESSIE COVERT

TO HELP YOU get more information quickly on the new products described in this section, we have provided the convenient Readers Service Form opposite page 216. Check the numbers on the card which correspond with the numbers at the close of each descriptive item in which you are interested. The MODERN HOSPITAL will send your requests to the manufacturers. If you wish other product information, just write us and we shall make every effort to supply it.

Cobalt 60 Cancer Therapy Machines



Two types of cobalt 60 cancer therapy machines are now available through the program of the General Electric Company, X-Ray Department, and Atomic Energy of Canada, Ltd. Both the AECL stationary, floor mounted unit designed for sources providing up to 100 roentgens per minute at 70 centimeters, known as the Model A Beam Therapy Unit, and the AECL Theratron, a new rotational cobalt unit in which the cobalt source, on one end of a large C-shaped support rotates by motor-drive continuously around the supine patient during treatment, delivering 30 roentgens per minute at 70 centimeters, are being offered in the United States.

The stationary unit weighs about 7000 pounds and may be moved through an arc of 105 degrees to achieve the best angle for treatment. The rotational unit, weighing 16,000 pounds, has a complete 360 degree rotation. The radiation emitted by cobalt 60 is slightly higher in wave length than that from a two million volt x-ray unit. **General Electric Co., X-Ray Department, 4855 Electric Ave., Milwaukee 1, Wis.**

For more details circle #864 on mailing card.

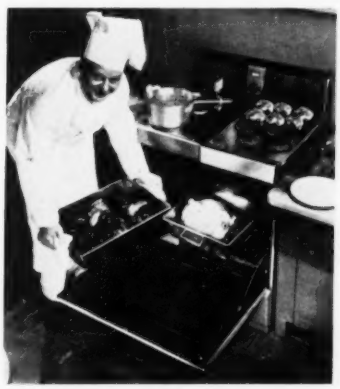
Paper Water Cup Has Flat Bottom

The new Lily decorated, one-piece paper water cup recently introduced has a sturdy flat bottom. The three-ounce cup is specially treated for added rigidity and has a tightly rolled rim for smooth drinking. The new method of manufacture has made possible a taller cup that is easier to hold, permits closer nesting and takes up less storage space. The dry-waxed surface treatment makes the cup ideal for use with fruit juices and other beverages as well as water. Known as the No. 44 cup, it is available with the stock green leaf design or in one-color special print. **Lily-Tulip Cup Corporation, 122 E. 42nd St., New York 17.**

For more details circle #865 on mailing card.

One Cooking Unit Handles All Requirements

An oven, a broiler, a surface cooker, a griddle and a fry kettle are combined in one compact, efficient unit in the Hotpoint Quintette. Described as a complete



packaged commercial cooking center, the unit is especially appropriate for diet kitchens, floor kitchens, training laboratories, contagious disease kitchens, personnel residences and other areas with specialized meal production problems.

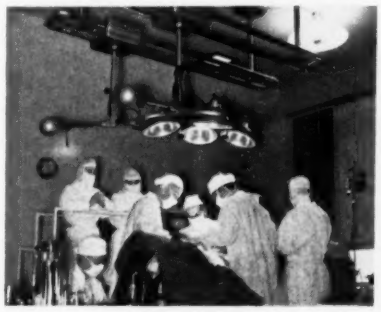
The five separate cooking units are combined in one compact piece of equipment just 30 inches wide, 36 3/16 inches to the cooking surface, and 29 inches deep. Two 6 inch and two 8 inch surface units, each with its own five heat switch control, are incorporated into the satin-chrome steel top. The left-rear unit serves as a three way convertible hot plate, deep-well cooker or fry kettle. A detachable griddle, with grease receptacle, clamps over the two right-hand units as a "duo-grid." Either half can be operated at separate temperatures or half may be shut off. The oven has push-button control and will handle roasting or baking, up to 45 pounds of meat or six 9 inch pies. Twelve 8 ounce steaks can be handled in the direct radiant heat broiler at one time. The Quintette is designed for simple and thorough cleaning. The body has a lustrous gray finish with bright red controls, and top and backsplasher are of satin-chrome. **Hotpoint Co., Commercial Equipment Dept., 227 S. Seeley Ave., Chicago 12.**

For more details circle #866 on mailing card.

Sterile Handle for Major Surgical Light

Detachable sterile handles, located close at hand, enable the surgeon to position four surgical lampheads for angled illumination of every portion of a deep surgical cavity during the operation. The new Castle Contra-Lite for specialized and general surgery, has extreme maneuverability of the mounting. The four lampheads can be grouped for maximum spot coverage, providing the effect of a major overhead light, or each may be worked independently for multiple angle illumination.

The four lampheads swivel within yokes, move through the up-and-down arc beneath tracks, and light each cavity surface from every angle. They are mounted parallel to the axis of the twin counterbalanced arms. The detachable focusing handle can be sterilized and attached just prior to use. The fixture



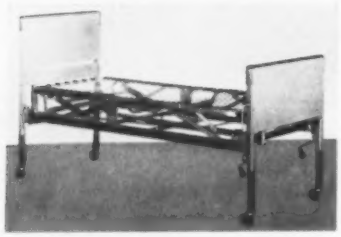
gives cool, glareless, color-corrected light for either overlapping concentrated spot or large area illumination. **Wilmot Castle Company, Rochester 7, N.Y.**

For more details circle #867 on mailing card.

(Continued on page 210)

What's New . . .

Variable Height Bed Has Single Crank Operation



The Single-Action Vari-Hite Bed provides comfort for patient and for nurse with a minimum of effort. But one cranking operation is required to raise or lower both head and foot ends of the bed, resulting in a saving of time and energy. A special gearing arrangement makes it possible for the nurse to raise even the heaviest patient without extra effort.

The bed can be quickly raised to nursing height with a few turns of the crank and as quickly returned to comfortable position for the patient so that he can get in and out without the need of a foot stool or the fear of falling. The bed is available in all standard Simmons colors and wood grain finishes. The improved two-crank spring permits a wide variety of positions, including shock and drainage position, without the use of blocks or elevating device. **Simmons Company, Merchandise Mart, Chicago 54.**

For more details circle #868 on mailing card.

Dual Drive on Dishwashing Machines

Completely separate operation is possible for wash and final rinse in dishwashing machines with the new type of V. B. dual drive arrangement. A motor is used to operate the power wash and a separate motor drives the conveyor to operate the final rinse. The new arrangement is available on single tank automatic conveyor type dishwashing machines. Glasses can be run through the machine, after a brush scrub, for a final sterilizing rinse only. The dual drive is quiet and vibrationless in operation, easy to service and maintain, and eliminates misalignment of pump and motor. **Universal Dishwashing Machinery Co., 49 Windsor Place, Nutley 10, N.J.**

For more details circle #869 on mailing card.

Pedestal Base Tables for Cafeterias

Two new tables were introduced recently especially for cafeteria use. They have single or double pedestal bases designed for perfect balance. The single-pedestal table has an island-type base with four flat horizontal legs, each equipped with an adjustable glide to give the table stability on uneven floors. On the two-pedestal table each has three horizontal legs to give good balance as well as comfortable leg room. Table bases are of heavy gauge, formed sheet steel in black crinkle finish with satin-finished kickplates to protect from scuffing. Royaloid is used for table tops with aluminum or self edges for easy cleaning. Tops are available in nine linen and wood grain colors. Tables are available in 30 to 42 inch square or round tops with one pedestal and in sizes from 30 by 60 inches to 36 by 72 inches in the larger double-pedestal styles. **Royal Metal Manufacturing Co., 175 N. Michigan Ave., Chicago 1.**

For more details circle #870 on mailing card.

Flush Mounting for Ovens and Incubators

A Flush-Mounting Assembly has been developed for "Precision-Freas" ovens, sterilizers and incubators used in hospitals and laboratories. The panel of polished, stainless steel permits recessing bulky cabinets in tile, brick, concrete or plaster walls, increasing the usable area of corridors, small rooms or other areas

where floor space is important. The Flush-Mounting Assemblies are stock units which stand flush with the surface. A dial thermometer with large, easily-read numerals is recessed in the top of the panel. The assemblies are quickly and easily attached to any type of wall up to 11½ inches thick. Seven sizes of assemblies are available. **Precision Scientific Co., 3737 W. Cortland St., Chicago 47.**

For more details circle #871 on mailing card.

Centrifugal Fan Ventilator Is Redesigned

A new one-section hood covers the motor chamber and directs air exhaust downward in the newly designed Airlift centrifugal fan ventilator. The hood lifts on swing-hinges in smaller models and is removable on large sizes. Removal of the hood provides easy access to motor and fan chambers for servicing and cleaning. The unit is designed primarily for low noise level dust exhaust and is available in fourteen sizes and a wide range of capacities. **The Swartwout Company, 18547 Euclid Ave., Cleveland 12, Ohio.**

For more details circle #872 on mailing card.

Refinishing Service for Metal Furniture

Old, worn metal furniture can be made bright and fresh with a new service performed right at the hospital. A fleet of two large vans, operated by the Aerial Service Company of De Forest, Wisconsin, an associate of Colonial Hospital Supply, moves into the hospital parking lot or nearby open area. Metal furniture is transferred to the vans and completely refinished on the spot, so that no room need be out of service for more than one day.

The service includes complete stripping of all old paint from the furniture, using a special sand blasting process. The furniture is carefully inspected and all rough spots ground off. In a spraying compartment a prime coat is applied, then baked in a special infra-red oven. The finish coat of enamel is then sprayed on and again baked for a highly durable finish that is scuff and chipproof, and resistant to liquids, soaps and cleaning compounds. A wide range of colors and finishes is available and two-tone combinations can also be applied. **Colonial Hospital Supply Co., 5645 N. Ashland Ave., Chicago 26.**

For more details circle #873 on mailing card.

Steam Deflector Protects Oven Finish

The new line of Griswold Artistocraft "54" Bake and Roast Ovens features a smoke and steam deflector over each door which protects the finish from discoloration and stain. The new line has the new Griswold hammertone finish which can be kept attractive with minimum maintenance since it is protected by the deflectors.

Air circulation under pans is provided with the new Pebble Deck which is said to eliminate burnt spots. The ovens have a potential possibility of pre-heating to 450 degrees in a half hour, thus providing a saving in time and money. Easy

deck level for single oven use is possible with the new 30 inch leg recently added to the line. **Griswold Manufacturing Co., 70 E. 45th St., New York 17.**

For more details circle #874 on mailing card.

What's New . . .

Glass Cleaner Prevents Fogging

A new all-purpose agent for cleaning glass, plastic and high luster surfaces is available in Klear-Glass. It prevents fogging of eye glasses, windshields, windows and optical surfaces caused by condensation and steam. It instantly restores optical brilliance to mirrored instruments, lenses and scopes, mirrors, glass panes and eye glasses. Treated surfaces remain fog-free and dust resistant for as much as two weeks after a few applications of Klear Glass. The liquid does not injure metals or delicate wood grain surfaces and is free of greasiness. It is supplied in pocket size and in "squeeze bottle" spray type containers for treating large surfaces. **The Buckley Corporation, 607 Fifth Ave., New York 17.**

For more details circle #875 on mailing card.

Safety Device for Patient's Bath

Patients who are permitted to take tub baths often have a problem in getting into and out of the tub. A device known as the Lifeguard is now available as a solution to the problem. This simple scientifically constructed device, developed in cooperation with an orthopedic surgeon, fits firmly on the edge of the bath tub. It provides a two-hand grip at the right height to permit the bather to stand erect while entering or leaving the tub. A horizontal bar is located near the rim of the tub to provide a firm grasp to assist the patient to a standing position.

The Lifeguard is sturdily constructed of strong alloy castings and heavy gauge steel tubing. It cannot scratch or mar porcelain because of the sponge rubber lining bonded to all parts that touch the tub. All parts grasped by the patient are coated with white rubber to prevent slipping. Heavy polished aluminum clamps hold the supporting members rigidly. The Lifeguard is offered in three styles to fit

any type of tub. **Bollen Products Company, 1366 Shawview Ave., East Cleveland 12, Ohio.**

For more details circle #876 on mailing card.

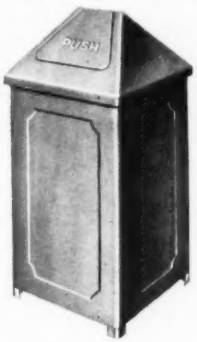
Laundry Operations Speeded With Self-Balancing Extractor

A fully automatic machine for speeding up laundry operations is offered in the new 24 inch Self-Balancing Extractor. The stainless steel basket is self-balancing so that it can be easily loaded even by inexperienced help. The design reduces vibration to a minimum. Automatic operation includes timer and brake. The machine is especially suited to hospital and other institutional laundry and can be furnished with single or three phase motor. **Chicago Dryer Co., Dept. H, 2210 N. Pulaski Rd., Chicago 39.**

For more details circle #877 on mailing card.

Waste Receptacle Has Streamlined Design

Modern streamlining has been applied to the Solar-Sturges self-closing waste receptacle line. These efficient units for sanitation and neatness have been redesigned for more attractive appearance. The swinging top still opens instantly, at a touch, to allow waste to be easily deposited, and swings closed gently and silently. They are easy to empty as the



top is merely tilted back, permitting easy removal of the inner container for emptying. There is only one moving part, in the swinging top, thus minimizing maintenance.

The new Solar waste receptacles have no sharp corners and can be used to encourage neatness in corridors, toilet rooms and washrooms, lockerrooms, cafeterias, laboratories and other areas. They are available in a number of sizes. **Solar-Sturges Mfg. Div., Pressed Steel Car Co., Inc., Melrose Park, Ill.**

For more details circle #878 on mailing card.

Double Scale Pharmaceutical Graduates

Made from extremely sturdy molded blanks, the new line of Mercer Double Scale Phamaceutical Graduates comply with all applicable Federal specifications, according to the manufacturer. They range in capacity from 10 ml to 1000 ml with corresponding ounce scale. All graduation marks are deeply acid etched, then filled with fused-in blue glass enamel. **Mercer Glass Works, Inc., 725 Broadway, New York 3.**

For more details circle #879 on mailing card.

Stainless Holloware Is Functional and Beautiful

The new Silco line of stainless holloware brought out by International features beauty of line and design which is at the same time highly functional. This quality assures fast, easy cleaning for sanitary service. The Deluxe Hi-Gloss finish adds to the attractiveness of the pieces and speeds up drying without streaking. The graceful proportions and smooth contours make the line especially pleasing for patient tray service.

The line is moderately priced and each piece is made to the most exacting standards to withstand the most rigorous usage for lasting serviceability. When properly washed and rinsed in hot water the holloware, like the flatware, requires no toweling and dries quickly, taking a minimum of time in washing facilities. The scratch-resistant finish requires no special care or polishing in normal use. The line comprises a wide variety of standard items for appropriate tray service. **International Silver Company, Meriden, Conn.**

For more details circle #880 on mailing card.

Multiple Copies Made Without Carbon Inserts

A new paper has been developed which can be used to make multiple copies of forms without the need of carbon paper inserts. The process uses combinations of two different coatings on ordinary paper, depending on how many copies are required. The new paper eliminates smudging and speeds efficiency in handling multiple copy forms. Called NCR (No Carbon Required) Paper, the new product produces clean, sharp copies when used with typewriter or pencil. **The National Cash Register Co., Dayton 9, Ohio.**

For more details circle #881 on mailing card.

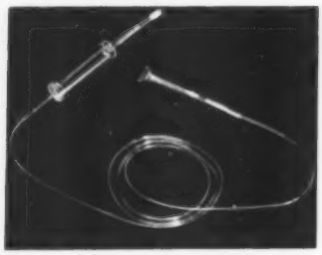
Gravity Rollers for Dish Rack Conveyor

Rust resistant gravity roller conveyors are a new development for dish rack return service. They are available in stainless or galvanized steel in standard widths of 6 and 22 inches. The rollers have rustproof bearings and can be furnished plain or rubber covered. **Samuel Olson Mfg. Company, Inc., 2431 Bloomingdale Ave., Chicago 47.**

For more details circle #882 on mailing card.

What's New . . .

Plastic Needle Shield for Expendable Sets



A flexible plastic shield covering the nylon needle adapter and detached needle is a new feature of the Cutter Saftiset With Needle which combines adaptability of use with additional safety. Extra advantages are supplied by having the needle detached inside a plastic case. The detached needle ensures complete sterilization of all surfaces, the needle can be attached just before administration, assuring tight fit, and the detached needle in the shield permits choice of another needle, or allows use of the needle with a syringe first, if desired. The new expendable intravenous set has all other Cutter features for efficient operation. **Cutter Laboratories, Berkeley 10, Calif.**

For more details circle #883 on mailing card.

Time System Is Self-Regulating

The new IBM 12-hour Self-Regulating Electronic Time System is designed to provide compensation for prolonged power interruptions due to storms, repairs and other unavoidable circumstances. All indicating clocks in the system that have fallen behind more than one hour are corrected twice each day. Time lags of 59 minutes or less, or fast errors of up to 55 seconds are supervised hourly and corrected in one minute as in other IBM time systems.

In the new system any desired hour may be selected for the 12-hour correction cycle and all clocks in the system are corrected automatically at that time. The new system requires no special clock and signal wiring, making installation costs nominal. Existing installations of IBM Self-Regulating Electronic or Synchronous-Wired Systems can be expanded to full 12-hour correction. **International Business Machines Corp., 590 Madison Ave., New York 22.**

For more details circle #884 on mailing card.

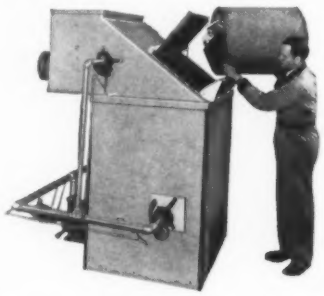
Prefinished Wall Painting for Speedy Installation

Labor costs in either new construction or remodeling can be saved in installations of the new Marlite Planks and Blocks. The tongue and groove prefinished wall paneling is speedily and economically installed. It is available in planks 16 inches wide and 8 feet long and in blocks 16 inches square. Both are 3/16 inch thick and come in ten new "companion colors," especially styled for Marlite Plank and Block, as well as in four authentic wood pattern finishes. The material is resistant to moisture, heat and stains, provides a permanent, soilproof surface that is easily cleaned, requires a minimum of maintenance and stays new looking for years. **Marsh Wall Products, Inc., Dover, Ohio.**

For more details circle #885 on mailing card.

Improved Incinerators Are Smokeless and Odorless

The new Model C-2 line of Wincinators incorporates the downdraft principle for smokeless and odorless operation. All models are designed to burn either wet or dry refuse and to meet the most rigorous building codes. They handle garbage, cartons, waste paper, wooden crates and other waste. A powerful pre-mix pressurizes the fuel to multiple burners for both primary and secondary combustion, as well as a secondary combustion chamber which incorporates a special smoke baffle, settling chamber and the



downdraft principle for complete combustion of smoke and odor.

The new line is equipped to burn natural, manufactured or bottled gas or oil. It is safe for installation either indoors or out and has heavy firebrick lining with latest safety devices. Over-sized feed doors make it easy to feed even large crates and boxes without breaking them up. **Winnen Incinerator Co., 932 Broadway, Bedford, Ohio.**

For more details circle #886 on mailing card.

Unitized Air Conditioner for Food Departments

A new Koch unitized air conditioner has been developed for efficient operation in food handling and service departments. It is available in 5 or 7½ h.p. sizes and cools, heats, ventilates and filters air quietly and economically. The new unit is simple to install and service and includes water, drain and electrical connections to be made at either end or rear, instant water connections, oilless fan bearings, parts easily accessible for servicing and optional stainless steel exterior. **Koch Refrigerators, Inc., North Kansas City, Mo.**

For more details circle #887 on mailing card.

Glassware Washers Developed for Laboratory Use

Specifically designed for processing glassware in laboratories, the new Laboratory Glassware Washers are powered by high pressure jet systems of such efficiency that even capillary pipettes are readily penetrated. Three new models are offered in the new series, encompassing loads of the smallest to the largest laboratories.

Culture media, organic and inorganic chemical deposits, oils, waxes and other tenaciously clinging soil are removed by the new washers. The glassware is washed, rinsed and optionally rinsed in distilled water. The simultaneous above and below pressure automatically holds the glassware in place in baskets during the cleaning operation. **Heinicke Instruments, 2035 Harding St., Hollywood, Fla.**

For more details circle #888 on mailing card.

Air Conditioning System Cools or Heats

The Electriglas Twin-Features is designed to keep a room cool or warm, as circumstances indicate. It is an air conditioning unit with a radiant glass heat panel. The dual-purpose unit, for wall mounting or window insertion, is controlled by three switches for ventilating, air conditioning and heating action. A thermostat maintains any desired year round temperature. **Electriglas Corp., Bergenfield, N.J.**

For more details circle #889 on mailing card.

Portable Dictating Machine Employs Belt for Recording

The new Dupli-Voice magnetic dictating and transcribing machine is a portable unit which employs a belt to record. It is small in size and light in weight and combines hi-fidelity performance and economy of magnetic recording. Magnetic recording can be used in the small unit because of the newly developed Erase-o-matic belt. The belt reproduces with high fidelity, can be

mailed or filed easily and used over and over again. **Dupli-Voice Co., Inc., Algonquin, Ill.**

For more details circle #890 on mailing card.

What's New . . .

Air Conditioning for Multi-Room Buildings

The "Flexazone" Central-Plant Air Conditioner is specifically designed for multi-room building applications where independent, variable cooling and heating are desired. The unit can be field-assembled in 24 different ways, depending upon available space. A new type damper arrangement makes it possible to add or change zones at any time, in the field.

Either horizontal or angular air flow is offered to fit individual space limitations. Cooling coils for use with water or direct expansion refrigerant are furnished in a wide variety of tube quantities. Standard steam coils are available for heat. The system has a number of exclusive features for more efficient and effective operation. **Drayer-Hanson, Inc., 3301 Medford St., Los Angeles 63, Calif.**

For more details circle #891 on mailing card.

Steel Wall Tile Facilities Renovation

A new ceramic-surfaced, low-cost steel wall tile has been developed especially for renovation of institutional buildings. The ceramic-surfaced material, Veos, is porcelain fused to steel and does not crack, craze or fade. It is especially effective for covering wall areas in lobbies, corridors, kitchens, bathrooms and other space where sanitation and ease of cleaning are problems. It can be rapidly applied on a patented grooved foundation board which gives a smooth, uniform sub-surface over existing walls, regardless of their condition. The tile is available in a full range of colors in 8 inch squares. **Porcelain Enamel Products Corp., Rehoboth, Mass.**

For more details circle #892 on mailing card.

Commercial Sizes in Food Waste Disposers

A complete line of commercial type food waste disposers, known as In-Sink-Erators, is now available for institutional use. These high-capacity grinders are equipped with ½ h.p. motors that operate on 115/230 volts and give a surplus power factor. Two models, like the illustration, are furnished with a stainless steel hopper measuring 15 and 18 inches respectively. Both include a scrap block and are designed to permit installation in metal counter tops. A third model, for fastening to a counter top with an opening of only 5⅞ inch diameter, has a smaller steel cone. A smaller model, made for attaching to a sink bowl with a 3½ or 4 inch strainer opening, is available for use in diet and floor kitchens.

The waste disposers help to speed up dish handling since food waste is either washed or scraped directly into the In-Sink-Erator unit. When the disposer switch is turned on, a flow of water is automatically delivered to the unit, washing the waste into the shredding chamber. **In-Sink-Erator Manufacturing Co., Racine, Wis.**

For more details circle #893 on mailing card.

Economical Fast Drying Offered in Electric Dryer

The new Model C Electric Hand Dryer offers faster, more economical and dependable hand drying. Designed for installation in institutional washrooms, it features twelve improvements and engineering advancements for increased efficiency. Included are increased air velocity and volume, permanent type air filter, touch action starter bar, new type revolving air baffle with non-breakable baffle guards, new vandalproof construction and attractive modern design. **Electric-Aire Engineering Corp., 209 W. Jackson Blvd., Chicago 6.**

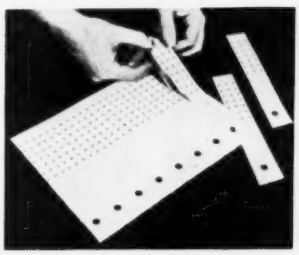
For more details circle #894 on mailing card.

All Stains Removed From Plastic Dinnerware

A new solution is now available which removes all stains from plastic dinnerware. It is completely non-toxic, will not corrode, is harmless to hands and completely removes stains from foods and beverages which sometimes make dishes unsightly. Known as Plastic-Dip, the product is easy to use and is odor-free. It is dissolved in warm or hot water, dishes are soaked for varying periods, depending on the amount of stain, and when rinsed are bright, sanitary and new looking. The product is economical in use as only a small amount is required for effective results. **The Diversey Corporation, 1820 W. Roscoe St., Chicago 13.**

For more details circle #895 on mailing card.

Waterproof Tape Used in Adhesive Strap



The new J & J Adhesive Strap is made with waterproof tape. Better ventilation to the skin area is provided by perforations in the portion of the Strap which goes against the patient's body. The new quick-stick adhesive mass used on all J & J Adhesive Straps holds them firmly in place as long as needed. The straps are supplied in convenient sheets approximately 8½ by 11¼ inches in size. **Johnson & Johnson, New Brunswick, N.J.**

For more details circle #896 on mailing card.

Flexible, Extendable Hose for Vacuum Cleaner

A light, extremely flexible hose has been developed for use with vacuum cleaners. Made up of a series of corrugations, the hose measures 5 feet in length while compressed, yet can be extended to a length of 15 feet, permitting the operator a wide radius of movement. As the operator moves back to the machine the hose retracts.

The Tornado Multi-Flex hose is light in weight and completely flexible, so that is can be used to clean around furniture without damaging or overturning it, thus making it especially effective for cleaning patients' rooms, waiting rooms or offices. It is equipped with molded cuffs at either end for quick attachment to tools and machines. The hose can be used on all Tornado vacuum cleaners and on all cleaners using 1½ inch commercial hose. **Breuer Electric Mfg. Co., 5100 N. Ravenswood Ave., Chicago 40.**

For more details circle #897 on mailing card.

Versatile Cleaning Cloth Made of Nylon

The KP Dish and Utility Cloth is a versatile nylon product. The quick drying, general purpose cleaning cloth can be used to clean and scour dishes, bottles and glasses, kitchen equipment, bathtubs and other porcelain equipment, pots and pans and other surfaces. It is especially effective in wiping woodwork, plastic mats and cloths, utensils, silverware and china without scratching or marring. It is equally effective when used in soap and water or as a damp cloth for many housekeeping and maintenance duties. **Webb Manufacturing Co., Fourth & Cambria Sts., Philadelphia 33, Pa.**

For more details circle #898 on mailing card.

What's New . . .

Four Panels in Lightweight Screen

A new Presco four-paneled screen has been developed which weighs less than six pounds and folds to two inch thickness from an extended position covering more than five feet. The one-piece tubular aluminum frame accounts for the extreme light weight of the screen. The glider base design and self-locking hinges make it virtually tipproof. The screen has vinyl panels which require no laundering but are easily cleaned with a light germicidal solution, without removing them from the frame. Panels are easily and quickly replaced with the "snap-out" curtain rods. The same screen is available with three panels. Panel colors offered are white, blue-gray, pastel rose or green. **Presco Company, Hendersonville, N.C.**

For more details circle #899 on mailing card.

Versatile Unit for Grounds Maintenance

Grounds care can be simplified with the new Jari Champion Mower. A feature of the new device is a "floating" Sickle Bar that follows the ground contour closely but automatically returns the bar to level position when raised to clear obstructions. The sickle bar can be guided with one hand. The wide-set, large wheels and low center of gravity keep the Champion from tipping even on steep slopes. Sickle bars are available in 36 and 44 inch lengths.

Lawn mower, sprayer and snow plow attachments are available for the new unit, thus making it a versatile, year-around maintenance device. The mower attachment can be used for heavy or light cutting, over rough or smooth ground, and will trim around flower beds and trees, under shrubbery and fences, and will cut brush, tall grass and weeds. **Jari Products, Inc., Minneapolis 8, Minn.**

For more details circle #900 on mailing card.

Sound Synchronized With Colored Pictures

The new Projectograph is fully automatic in operation, with sound synchronized with brilliant colored pictures. It is designed for effective audio-visual presentations. Words or music are now electrically indexed on Mylar long-life recording tape. Each picture is individually controlled by its own message on the tape. Each message may be of any length with the picture remaining on the screen for the full duration of the sound. The playback unit repeats up to 15 minutes of sound continuous with the tape in a self-contained cartridge. The Projectograph is available in a luggage-type case or cabinet for easy portability. It is also available in a new series of custom wood cabinets if desired to harmonize with surroundings. **Projectograph Corp., Oshkosh, Wis.**

For more details circle #901 on mailing card.

Service Cart Has Three Shelves

The Model 150 Service Cart is ruggedly constructed of mirror finished stainless steel throughout. It is easy to keep clean, has a load capacity of approximately 250 pounds, and can be used as a mobile or as a stationary rack. The cart is fitted with three shelves, each 15½ by 24 inches in size. Removable 3 inch noiseless soft rubber ball-bearing swivel caster

wheels make it easily moved as required. The cart is equally serviceable for use in handling or storage of food, dishes, surgical supplies or other items in the hospital. **The Craft Manufacturing Co., 3949 W. Schubert, Chicago 47.**

For more details circle #902 on mailing card.

Quick Cooked Chow Mein Offers Menu Variety

Only 12 minutes of cooking are necessary to provide a Chow Mein dinner with the authentic flavor of the fresh-cooked dish. This is possible with the Croyden House Chow Mein Dinner recently introduced for institutional use. It is a dehydrated Chow Mein package mix which is quick, economical and provides an interesting variety for the diet. It is supplied with or without quick-cooking raw rice in a 22 ounce regular institutional package which will make a gallon of Chow Mein at a moderate price. The package can be stored indefinitely and dinners can be prepared in the quantity desired in a minimum of time. **Croyden Mills, Suffern, N.Y.**

For more details circle #903 on mailing card.

Room Air Conditioner Has Flush Exterior

Flush exterior mounting within the glass line, allowing the window to be closed behind it when not in use, is a feature of a new room air conditioner recently introduced. The new unit is the institutional model in the Fresh'nd-Aire Electromagnetic Push-Button Automatic Room Air Conditioner line. It permits installation of room air conditioners without detracting from the exterior view of the hospital.

The new model sits rigidly just inside the window. When the lower sash is opened to the weather-sealing extrusion, Fresh'nd-Aire's Air-O-Shroud keeps the unit operating at normal top cooling efficiency. This U-shaped steel housing fits snugly over the back section of the cabinet. It permits a large volume of outside air to enter the side vents of the cabinet for rapid outside evaporation. The "Silence-Guard" deadens irritating operating noise so that even with the unit inside the room it does not disturb patients or personnel. **Cory Corporation, 221 N. La Salle St., Chicago 1.**

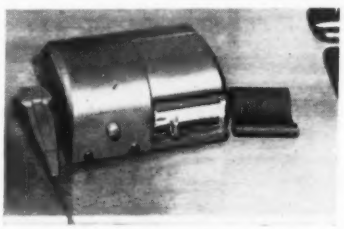
For more details circle #904 on mailing card.

Endless Magnetic Belt on Dictating Machine

Advanced electronic features are used in the new Peirce magnetic Dictation machine which employs an endless magnetic belt as the recording medium. The machine is completely electronic and is the result of three years of intensive research by Peirce and by the Armour Research Foundation of Chicago.

Electronic dictation permits the quick correction of errors and the dictation of changes without notes or slips. The belt is backed to the point where the correction is to begin, and the corrected material is dictated right over the original, which is automatically removed.

The machine is built into a light weight, portable case which is attractive in design and operates with simple finger tip control. Every operating control is centered on the hand microphone for ease and convenience. The new equipment can be used as a combination dictator and transcriber or a separate transcribing unit is available. An exclusive



feature of the new machine is the automatic back-spacer for ease of transcription. **Peirce Dictation Systems, 5900 N. Northwest Highway, Chicago 31.**

For more details circle #905 on mailing card.

What's New . . .

Pre-Packaged Chemicals for Parenteral Solutions

Minimum storage space is required for the new Accurette system for making parenteral solutions. The technic is the result of years of research and consultation with hospital staff members. It is a versatile, simple, accurate and economical system for producing sterile solutions as needed, in a minimum of time.

The pyrogen-free, dry chemical, premeasured to the exact quantity to produce 1000 ml. of solution, is provided pre-packaged. Solutions are made by emptying the contents of the Accurette into a dry flask, filling the flask with distilled water of the proper amount, capping and autoclaving. The resulting product is ready to be dispensed topically or intravenously.

Accurettes now available include Sodium Chloride, Ringer's Solution, Dextrose (in standard percentages), Dextrose and Saline, Invert Sugars and Electrolytes. For irrigating solutions the Normal Saline and Ringers can be prepared quickly as required. Preparation of electrolyte solutions for almost every possible requirement can be achieved simply and quickly with Accurettes. **Macalaster Bicknell Parenteral Corp., 243 Broadway, Cambridge, Mass.**

For more details circle #906 on mailing card.

Oxygen Mask Is Disposable

An improved model of the Plastic Mix-O-Mask is now available. The facepiece is designed to fit most patients, the reservoir bag is slightly larger, to maintain an adequate supply of oxygen and air, and the mask is fully disposable. The inspiratory, expiratory and emergency air intake valves are all positive acting. The plastic air mixing venturi device is precalibrated so that a definite therapeutic concentration is continuously maintained. The O.E.M. Disposable Mix-O-Mask is a non-breathing mask, thus eliminating any build-up of carbon-dioxide. **O.E.M. Corporation, East Norwalk, Conn.**

For more details circle #907 on mailing card.

Surgical Binder Has Self-Fasteners

Self-Locking Buckles are used to hold the new Muller Surgical Binder in place. The binder is easily removed and as easily adjusted for comfort. It is made in a range of sizes and is available in both abdominal and chest types. The binder is loosened or tightened by web strips which fasten it, without accessories, when used after surgery or whenever dressings must be held in place. It is a shaped, single sheet binder which can be laundered. The self-locking buckles are removed for laundering and easily replaced. **The Texal Co., 510 First Ave., N., Minneapolis 3, Minn.**

For more details circle #908 on mailing card.

Pharmaceuticals

Nidar

Nidar is a new formulation of sedative drugs for individualized control of tension peaks, through the combination of four barbiturates of varying periods and onsets of action. Each light-green, scored Nidar tablet contains ⅜ gr. secobarbital sodium, ⅜ gr. pentobarbital sodium, ⅛ gr. butabarbital sodium and ⅛ gr. phenobarbital. The combination of short, medium and long-acting barbiturates gives quick response and builds up to a peak in periods of tension. **The Armour Laboratories, 520 N. Michigan Ave., Chicago 11.**

For more details circle #909 on mailing card.

Crystoserpine

Crystoserpine, crystalline reserpine, is a mild to moderate hypotensive agent. Reserpine, a single alkaloid derived from Rauwolfia serpentina, produces the hypotensive, sedative and bradycrotic actions characteristic of the crude drug. Crystoserpine is offered as the sole therapeutic agent for many patients with essential hypertension. It is described as an unusually safe drug. **Smith-Dorsey, Lincoln, Neb.**

For more details circle #910 on mailing card.

Cortril Tablets

Cortril Tablets, for enhanced oral anti-inflammatory therapy, are indicated for the management of rheumatoid arthritis and allied conditions, acute rheumatic fever, Addison's disease, bronchial asthma, acute and chronic ocular disorders and other conditions amenable to oral anti-inflammatory hormone therapy. Cortril is available in the following dosage forms: Cortril Tablets, 10 and 20 mg. each; Cortril Acetate Ophthalmic Suspension with Terramycin, 15 mg. of hydrocortisone acetate and 5 mg. of Terramycin hydrochloride per cc; Cortril Acetate Ophthalmic Ointment in ⅛ ounce tubes in two strengths; Cortril Acetate Topical Ointment in 1/6 ounce tubes in two strengths, and Cortril Acetate Aqueous Suspension for intra-articular injection in 5 cc. vials, 25 mg. per cc. **Pfizer Laboratories, Division, Chas. Pfizer & Co., Inc., 630 Flushing Ave., Brooklyn 6, N.Y.**

For more details circle #911 on mailing card.

Lotion Surfadil

Lotion Surfadil is for palliative relief of sunburn, insect bites, and ivy, oak and sumac poisoning. The formula is a combination of Histadyl and Surfacaine with titanium dioxide as a superior spreading and drying agent. It is pleasantly scented, has a flesh-tone color and is supplied in a handy unbreakable plastic bottle. **Eli Lilly and Company, Indianapolis 6, Ind.**

For more details circle #912 on mailing card.

Human Albumin for Rh Testing Procedures

Human Albumin solution for Rh testing procedures contains sodium azide 1:1000 as a preservative and the manufacturer warns that it is not to be used for injection. It is a serum albumin, obtained by the fractionation of plasma, described as a suitable source of a stable, high protein medium for serologic determinations. Albumin for serologic use is furnished as a solution containing 30 grams per 100 cc. The widest use of concentrated albumin solution is indicated in the study of blood agglutinins of the blocking type such as Rh and Hr sensitizations, as well as lesser known antibodies which require conglutinin for their detection. It may also be employed in the crossmatching of donor and recipient blood as well as in other serologic determinations. **Hyland Laboratories, 4501 Colorado Blvd., Los Angeles 39, Calif.**

For more details circle #913 on mailing card.

Monodral Bromide

Monodral Bromide is a new agent introduced for ulcer control. Monodral is an orally effective anticholinergic drug which is particularly effective in inhibiting gastric motility and secretion. Its greatest clinical usefulness is said to be in peptic ulcer, hyperacidity, gastritis, pylorospasm and other upper gastro-intestinal tract disorders. Monodral Bromide is supplied in Caplets of 5 mg., in bottles of 100. **Winthrop-Stearns, Inc., 1450 Broadway, New York 18.**

For more details circle #914 on mailing card.

Primoplex

Primoplex is a new geriatric liver and vitamins preparation supplied in vials with 2 cc. ampuls of diluent for intramuscular administration. It is indicated for prevention and treatment of B complex deficiencies and is a valuable adjunct in nutritional deficiencies of all ages and for pre-operative and post-operative supplementation. **Lederle Laboratories Division, American Cyanamid Company, Pearl River, N.Y.**

For more details circle #915 on mailing card.

Polycycline

Polycycline is a new broad-spectrum antibiotic tetracycline in capsule form. It provides broad-spectrum effectiveness against both gram-positive and gram-negative bacteria sensitive to chlortetracycline or oxytetracycline, plus efficacy against penicillin-resistant organisms. The product is rapidly absorbed, stable, attains high serum concentrations quickly and shows a low incidence of disagreeable side reactions. **Bristol Laboratories Inc., Syracuse 1, N.Y.**

For more details circle #916 on mailing card.

What's New . . .

Product Literature

• **"Protecting the Public Health"** is the title of a 32 page booklet published by E. I. du Pont de Nemours & Co., Inc., Wilmington 98, Del. It tells the story of how a large manufacturing company fulfills its responsibility toward the public health and protection. Activities of the Haskell Laboratory for Toxicology and Industrial Medicine are described in words and pictures. The far reaching results on people and products of the studies conducted by this research organization are discussed.

For more details circle #917 on mailing card.

• A new folder offering sizes, thicknesses, feature strip sizes and colors of **Flexachrome Vinyl Plastic-Abestos Floor Tile** is now available through The Tile-Tex Div., The Flintkote Co., Chicago Heights, Ill. Illustrations are given showing the use of this floor tile in school libraries and hospitals.

For more details circle #918 on mailing card.

• The advantages of high temperature water over steam are presented in a new 16 page booklet entitled, **"Hydrotherm Bulletin No. 100,"** issued by American Hydrotherm Corp., 33-70 12th St., Long Island City 6, New York. The text discusses and illustrates the applications of high temperature high pressure water in distributing heat to large area installations such as schools, colleges, hospitals and other institutions.

For more details circle #919 on mailing card.

• The new Servisafe line of metal pole units designed to permit safe, efficient ground-level luminaire servicing is discussed in the new 32 page catalog, **"Thompson Servisafe Units for Pole and Wall Mounted Luminaires."** Released by Thompson Electric Company, 1128 Power Ave., Cleveland 14, Ohio, Catalog No. PB-53 covers four Servisafe models and a variety of adapters and accessories available for use with them.

For more details circle #920 on mailing card.

• The complete series of **Fisher Serological Water Baths** is described in a new bulletin recently released by Fisher Scientific Company, 717 Forbes St., Pittsburgh 19, Pa. Information is given on the improvements in the line of serological water baths, temperature control and design.

For more details circle #921 on mailing card.

• An instructive and helpful booklet has been published by the Globe Automatic Sprinkler Co., 250 Park Ave., New York 17. Entitled **"How to Detect and Stop Fire Automatically,"** the booklet is offered "as a solution of your fire protection problems." How proper protection affects insurance costs is discussed and there is complete information on Globe Saveall Automatic Sprinklers and how and where they are installed.

For more details circle #922 on mailing card.

• A new cardboard device called the **Florule** has just been brought out by Multi-Clean Products, Inc., 2277 Ford Pkwy., St. Paul 1, Minn. Described as **"a guide to better floor finishing,"** the Florule gives information on how to treat various types of floors. The 4 by 6 inch card has a rotating dial which, when pointed to the name of a type of flooring, discloses the proper floor materials to use, coverage per gallon, drying time and method of application.

For more details circle #923 on mailing card.

• **Technical Bulletin T-011** covering the installation of emergency standby generating plants and automatic line transfer controls has just been released by D. W. Onan & Sons, Inc., 6251 University Ave., Minneapolis 14, Minn. Descriptions of standby electric generating plants, methods of control and easy-to-understand diagrams are included in the booklet.

For more details circle #924 on mailing card.

A special catalog on **"Medical Repair Parts"** for Liquid medical regulators, humidifiers and cylinder yoke-needle valves is now available from the Medical Gas Division, The Liquid Carbonic Corporation, 3100 S. Kedzie Ave., Chicago 23. Known as Bulletin No. 5469, it was published to simplify ordering of repair parts and illustrates and describes each part of each unit in detail.

For more details circle #925 on mailing card.

• A new booklet describing the **Lamson Selective Vertical Conveyors, Bookveyors and Clinical History Lifts** has been released by Lamson Corp., 3100 James St., Syracuse 1, New York. By performing all necessary actions automatically, these conveyors provide all users with floor-to-floor distribution systems that require the least time, thought, effort and maintenance—yet offer complete safety of operation in use.

For more details circle #926 on mailing card.

• Several newly introduced apparatus and equipment items for the laboratory are illustrated and described in the new 16 page **Catalog No. LO-1253** published by Schaar and Company, 754 W. Lexington St., Chicago 7. Included are a new laboratory muller, porous bottom crucible, stirring apparatus, all-purpose penetrometer and two additions to the line of polyethylene laboratory ware.

For more details circle #927 on mailing card.

• The complete line of P-K hot water storage heaters is pictured and described in the new 48 page **Catalog Number 18** issued by The Patterson-Kelley Co., Inc., 614 Warren St., East Stroudsburg, Pa. The catalog is printed in color and black and white and gives data on the various types of hot water heaters with full specifications and conversion tables. Piping diagrams are given for high and low pressure steam systems, with average water requirements of typical hot water fixtures in various types of buildings.

For more details circle #928 on mailing card.

• A new catalog designed primarily for hospital architects, designers, planning boards and management personnel has just been released by Maysteel Products, Inc., 740 Plankinton Ave., Milwaukee 3, Wis. The catalog provides a source of **hospital casework specifications and construction details** arranged in a quick and easy-to-use system. Drawings include items such as plumbing fixtures, sinks, wardrobe and wardrobe assemblies. Installation photographs are included throughout the publication.

For more details circle #929 on mailing card.

• A new instructive **buying guide,** known as **Form 2164,** is now being offered by Wyandotte Chemicals Corp., Wyandotte, Mich. The form lists 15 Wyandotte products for dishwashing, sanitation and maintenance operations with ideas which should either improve quality or lower costs, or both.

For more details circle #930 on mailing card.

• A complete new **photocopy information kit** has been compiled by the American Photocopy Equipment Co., 1920 W. Peterson, Chicago 26. The kit has been prepared to help the executive solve the problem of copying material with a minimum of effort. Included in the kit is a new book on the Apeco Systematic Auto-Stat copier which describes this copying development with diagrams, uses, comparison charts, applications, photographs and other data.

For more details circle #931 on mailing card.

• A new catalog outlining uses for **Asymmetric Silver-mirrored Permaflectors** and listing over 500 types, sizes and assemblies has been released by Pittsburgh Reflector Co., 419 Oliver Bldg., Pittsburgh 22, Pa. The bulletin tells the values of various types of reflecting surfaces so that the user may know the proper reflecting surface to select for obtaining maximum foot-candle efficiency. It goes into the advantages of particular types of reflectors for varying work.

For more details circle #932 on mailing card.

Book Announcements

Bogert, "Nutrition and Physical Fitness," 6th Ed., 666 pp. with 111 figures, $4.50. Harrow, "Textbook of Biochemistry," 6th Ed., 563 pp. with 131 figures, $6.50. Brown, "Psychodynamic Nursing," 257 pp., $3.50. Price, "The Art, Science and Spirit of Nursing," 882 pp. with 275 figures, $5.50. Rathbone, "Corrective Physical Education," 6th Ed., 318 pp. with 35 figures, $4.50. **W. B. Saunders Co., W. Washington Square, Philadelphia 5, Pa.**

For more details circle #933 on mailing card.

Supplier's News

The Swartzbaugh Mfg. Co., manufacturer of food handling equipment, announces removal of its offices and plant from **Toledo, Ohio,** to **Murfreesboro, Tenn.** as of April 1, 1954.

USE THIS CARD

(We pay the postage)

This card is detachable and is provided for the convenience of our subscribers, and those to whom they pass their copies, in obtaining information on products and services advertised in this issue or described in the "What's New" Section. See reverse side.

July, 1954

Please ask the manufacturers, indicated by the numbers I have circled, to send further literature and information provided there is no charge or obligation.

WHAT'S NEW

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NAME _____ TITLE _____

INSTITUTION _____

ADDRESS _____ CITY _____ ZONE _____ STATE _____

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Product Literature

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For more details circle #918 on mailing card.

• The advantages of high temperature water over steam are presented in a new 16 page booklet entitled, **"Hydrotherm Bulletin No. 100,"** issued by American Hydrotherm Corp., 33-70 12th St., Long Island City 6, New York. The text discusses and illustrates the applications of high temperature high pressure water in distributing heat to large area installations such as schools, colleges, hospitals and other institutions.

For more details circle #919 on mailing card.

• The new Servisafe line of metal pole units designed to permit safe, efficient ground-level luminaire servicing is discussed in the new 32 page catalog, **"Thompson Servisafe Units for Pole and Wall Mounted Luminaires."** Released by Thompson Electric Company, 1128 Power Ave., Cleveland 14, Ohio, Catalog No. PB-53 covers four Servisafe models and a variety of adapters and accessories available for use with them.

For more details circle #920 on mailing card.

• The complete series of **Fisher Serological Water Baths** is described in a new bulletin recently released by Fisher Scientific Company, 717 Forbes St., Pittsburgh 19, Pa. Information is given on the improvements in the line of serological water baths, temperature control and design.

For more details circle #921 on mailing card.

• An instructive and helpful booklet has been published by the Globe Automatic Sprinkler Co., 250 Park Ave., New York 17. Entitled **"How to Detect and Stop Fire Automatically,"** the booklet is offered "as a solution of your fire protection problems." How proper protection affects insurance costs is discussed and there is complete information on Globe Saveall Automatic Sprinklers and how and where they are installed.

For more details circle #922 on mailing card.

• A new cardboard device called the **Florule** has just been brought out by Multi-Clean Products, Inc., 2277 Ford Pkwy., St. Paul 1, Minn. Described as **"a guide to better floor finishing,"** the Florule gives information on how to treat various types of floors. The 4 by 6 inch card has a rotating dial which, when pointed to the name of a type of flooring, discloses the proper floor materials to use, coverage per gallon, drying time and method of application.

For more details circle #923 on mailing card.

• **Technical Bulletin T-011** covering the installation of emergency standby generating plants and automatic line transfer controls has just been released by D. W. Onan & Sons, Inc., 6251 University Ave., Minneapolis 14, Minn. Descriptions of standby electric generating plants, methods of control and easy-to-understand diagrams are included in the booklet.

For more details circle #924 on mailing card.

A special catalog on **"Medical Repair Parts"** for Liquid medical regulators, humidifiers and cylinder yoke-needle valves is now available from the Medical Gas Division, The Liquid Carbonic Corporation, 3100 S. Kedzie Ave., Chicago 23. Known as Bulletin No. 5469, it was published to simplify ordering of repair parts and illustrates and describes each part of each unit in detail.

For more details circle #925 on mailing card.

• A new booklet describing the **Lamson Selective Vertical Conveyors, Bookveyors and Clinical History Lifts** has been released by Lamson Corp., 3100 James St., Syracuse 1, New York. By performing all necessary actions automatically, these conveyors provide all users with floor-to-floor distribution systems that require the least time, thought, effort and maintenance—yet offer complete safety of operation in use.

For more details circle #926 on mailing card.

• Several newly introduced apparatus and equipment items for the laboratory are illustrated and described in the new 16 page **Catalog No. LO-1253** published by Schaar and Company, 754 W. Lexington St., Chicago 7. Included are a new laboratory muller, porous bottom crucible, stirring apparatus, all-purpose penetrometer and two additions to the line of polyethylene laboratory ware.

For more details circle #927 on mailing card.

• The complete line of P-K hot water storage heaters is pictured and described in the new 48 page **Catalog Number 18** issued by The Patterson-Kelley Co., Inc., 614 Warren St., East Stroudsburg, Pa. The catalog is printed in color and black and white and gives data on the various types of hot water heaters with full specifications and conversion tables. Piping diagrams are given for high and low pressure steam systems, with average water requirements of typical hot water fixtures in various types of buildings.

For more details circle #928 on mailing card.

• A new catalog designed primarily for hospital architects, designers, planning boards and management personnel has just been released by Maysteel Products, Inc., 740 Plankinton Ave., Milwaukee 3, Wis. The catalog provides a source of **hospital casework specifications and construction details** arranged in a quick and easy-to-use system. Drawings include items such as plumbing fixtures, sinks, wardrobe and wardrobe assemblies. Installation photographs are included throughout the publication.

For more details circle #929 on mailing card.

• A new instructive **buying guide,** known as **Form 2164,** is now being offered by Wyandotte Chemicals Corp., Wyandotte, Mich. The form lists 15 Wyandotte products for dishwashing, sanitation and maintenance operations with ideas which should either improve quality or lower costs, or both.

For more details circle #930 on mailing card.

• A complete new **photocopy information kit** has been compiled by the American Photocopy Equipment Co., 1920 W. Peterson, Chicago 26. The kit has been prepared to help the executive solve the problem of copying material with a minimum of effort. Included in the kit is a new book on the Apeco Systematic Auto-Stat copier which describes this copying development with diagrams, uses, comparison charts, applications, photographs and other data.

For more details circle #931 on mailing card.

• A new catalog outlining uses for **Asymmetric Silver-mirrored Permaflectors** and listing over 500 types, sizes and assemblies has been released by Pittsburgh Reflector Co., 419 Oliver Bldg., Pittsburgh 22, Pa. The bulletin tells the values of various types of reflecting surfaces so that the user may know the proper reflecting surface to select for obtaining maximum foot-candle efficiency. It goes into the advantages of particular types of reflectors for varying work.

For more details circle #932 on mailing card.

Book Announcements

Bogert, "Nutrition and Physical Fitness," 6th Ed., 666 pp. with 111 figures, $4.50. Harrow, "Textbook of Biochemistry," 6th Ed., 563 pp. with 131 figures, $6.50. Brown, "Psychodynamic Nursing," 257 pp., $3.50. Price, "The Art, Science and Spirit of Nursing," 882 pp. with 275 figures, $5.50. Rathbone, "Corrective Physical Education," 6th Ed., 318 pp. with 35 figures, $4.50. **W. B. Saunders Co., W. Washington Square, Philadelphia 5, Pa.**

For more details circle #933 on mailing card.

Supplier's News

The Swartzbaugh Mfg. Co., manufacturer of food handling equipment, announces removal of its offices and plant from **Toledo, Ohio,** to **Murfreesboro, Tenn.** as of April 1, 1954.

PRODUCT INFORMATION

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864 Cancer Therapy Machine
General Electric Company

865 Flat-Bottomed Water Cup
Lily-Tulip Cup Corp.

866 Quintette Cooking Unit
Hotpoint Company

867 Contra-Lite
Wilmot Castle Company

868 Vari-Hite Bed
Simmons Company

869 Dual Drive for Dishwashers
Universal Dishwashing Machinery Co.

870 Cafeteria Tables
Royal Metal Mfg. Co.

871 Flush-Mounting Assembly
Precision Scientific Co.

872 Centrifugal Fan Ventilator
The Swartwout Company

873 Refinishing Service
Colonial Hospital Supply Co.

874 Artistocraft "54" Ovens
Griswold Manufacturing Co.

875 Klear-Glass
The Buckley Corporation

876 Lifeguard
Bollen Products Company

877 Self-Balancing Extractor
Chicago Dryer Company

878 Redesigned Waste Receptacle
Solar-Sturges Mfg. Division

879 Pharmaceutical Graduates
Mercer Glass Works, Inc.

880 Silco Stainless Holloware
International Silver Company

881 NCR Paper
The National Cash Register Co.

882 Dish Rack Conveyor
Samuel Olson Mfg. Co., Inc.

883 Saftiset With Needle
Cutter Laboratories

884 Electronic Time System
International Business Machines Corp.

885 Marlite Planks and Blocks
Marsh Wall Products, Inc.

886 Model C-2 Wincinators
The Winnen Incinerator Co.

887 Unitized Air Conditioner
Koch Refrigerators, Inc.

Key

888 Laboratory Glassware Washers
Heinicke Instruments

889 Air Conditioning Unit
The Electriglas Corp.

890 Dictating & Transcribing Machine
Dupli-Voice Co., Inc.

891 Central Air Conditioner
Drayer-Hanson, Inc.

892 Steel Wall Tile
Porcelain Enamel Products Corp.

893 In-Sink-Erators
In-Sink-Erator Mfg. Co.

894 Electric Hand Dryer
The Electric-Aire Engineering Corp.

895 Plastic-Dip
The Diversey Corp.

896 Adhesive Strap
Johnson & Johnson

897 Multi-Flex Hose
Breuer Electric Mfg. Co.

898 Dish and Utility Cloth
Webb Manufacturing Co.

899 Four-Paneled Screen
Presco Company

900 Champion Mower
Jari Products, Inc.

901 Improved Projectograph
Projectograph Corp.

902 Service Cart
Craft Manufacturing Co.

903 Chow Mein Dinner
Croyden Mills

904 Electromagnetic Air Conditioner
Cory Corporation

905 Magnetic Dictating Machine
Peirce Dictation Systems

906 Accurette System
Macalaster Bicknell Parenteral Corp.

907 Plastic Mix-O-Mask
O.E.M. Corporation

908 Muller Surgical Binder
The Texal Company

909 Nidar
The Armour Laboratories

910 Cortril Tablets
Pfizer Laboratories

Key

911 Crystoserpine
Smith-Dorsey

912 Lotion Surfadil
Eli Lilly and Company

913 Human Albumin
Hyland Laboratories

914 Monodral Bromide
Winthrop-Stearns

915 Primoplex
Lederle Laboratories

916 Polycycline
Bristol Laboratories, Inc.

917 "Protecting the Public Health"
E. I. du Pont de Nemours & Co., Inc.

918 "Flexachrome Floor Tile"
The Tile-Tex Division

919 "Hydrotherm Bulletin #100"
American Hydrotherm Corp.

920 "Thompson Servisafe Units . ."
Thompson Electric Company

921 Serological Water Baths
Fisher Scientific Company

922 Detect and Stop Fires
Globe Automatic Sprinkler Co., Inc.

923 Multi-Clean Florule
Multi-Clean Products, Inc.

924 Technical Bulletin T-011
D. W. Onan & Sons

925 Medical Repair Parts
The Liquid Carbonic Corp.

926 Conveyors, Bookveyors, & Clinical Lifts
Lamson Corp.

927 Catalog #LO-1253
Schaar and Company

928 Catalog #18
The Patterson-Kelley Co., Inc.

929 Hospital Casework Catalog
Maysteel Products, Inc.

930 Form 2164
Wyandotte Chemicals Corp.

931 Photocopy Information Kit
American Photocopy Equipment Co.

932 Silver-Mirrored Permaflectors
Pittsburgh Reflector Co.

933 Book Announcements
W. B. Saunders Company

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(HPF) after company name indicates that further descriptive data are filed in catalog space in HOSPITAL PURCHASING FILE—31st Edition

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Now Aro-Brom, G. S. is the *first* germicide to offer you proof of general effectiveness for Aro-Brom, G. S. confirms when tested to the rigid standards of the new Use Dilution Performance Test.

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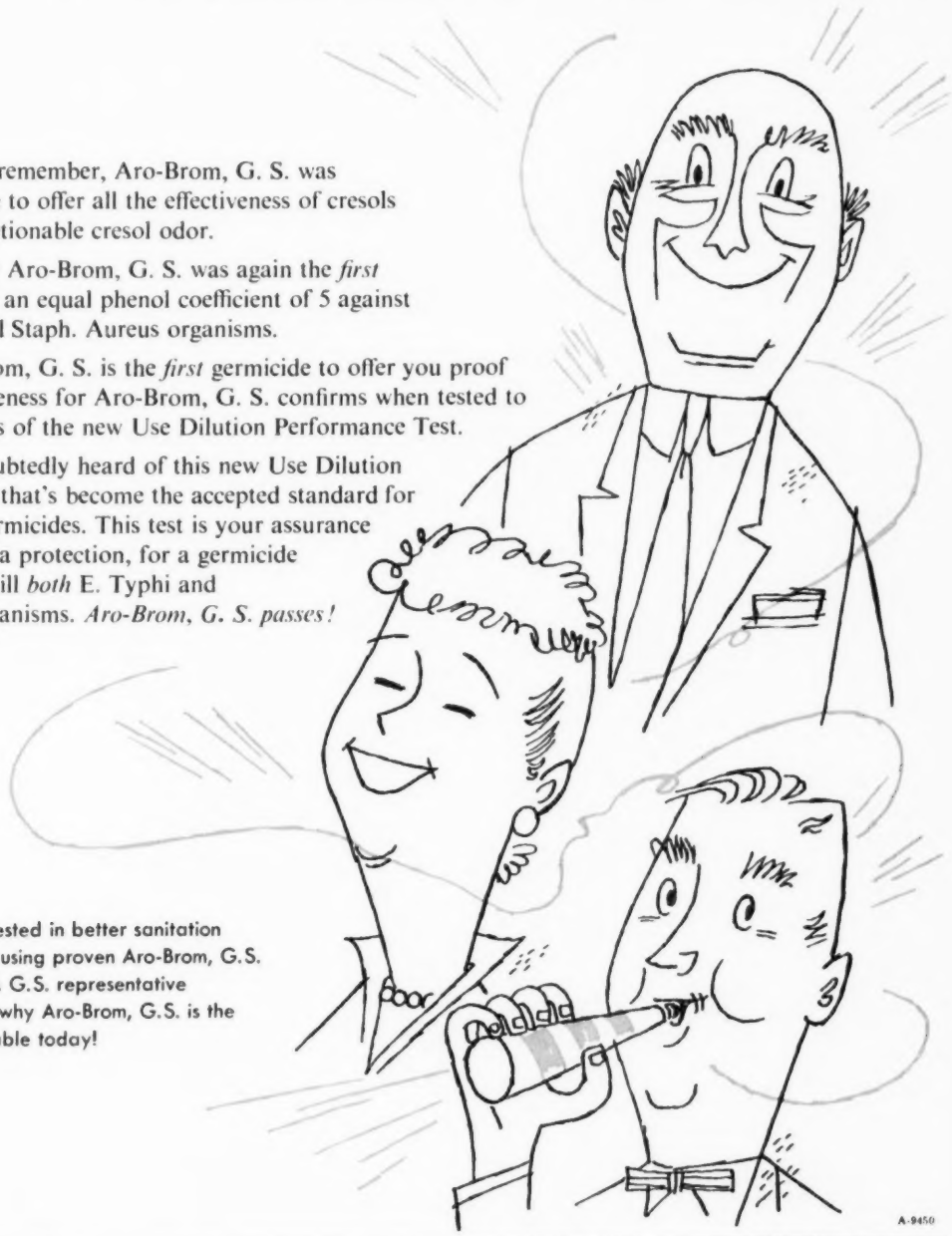

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Index to Products Advertised—*Continued*

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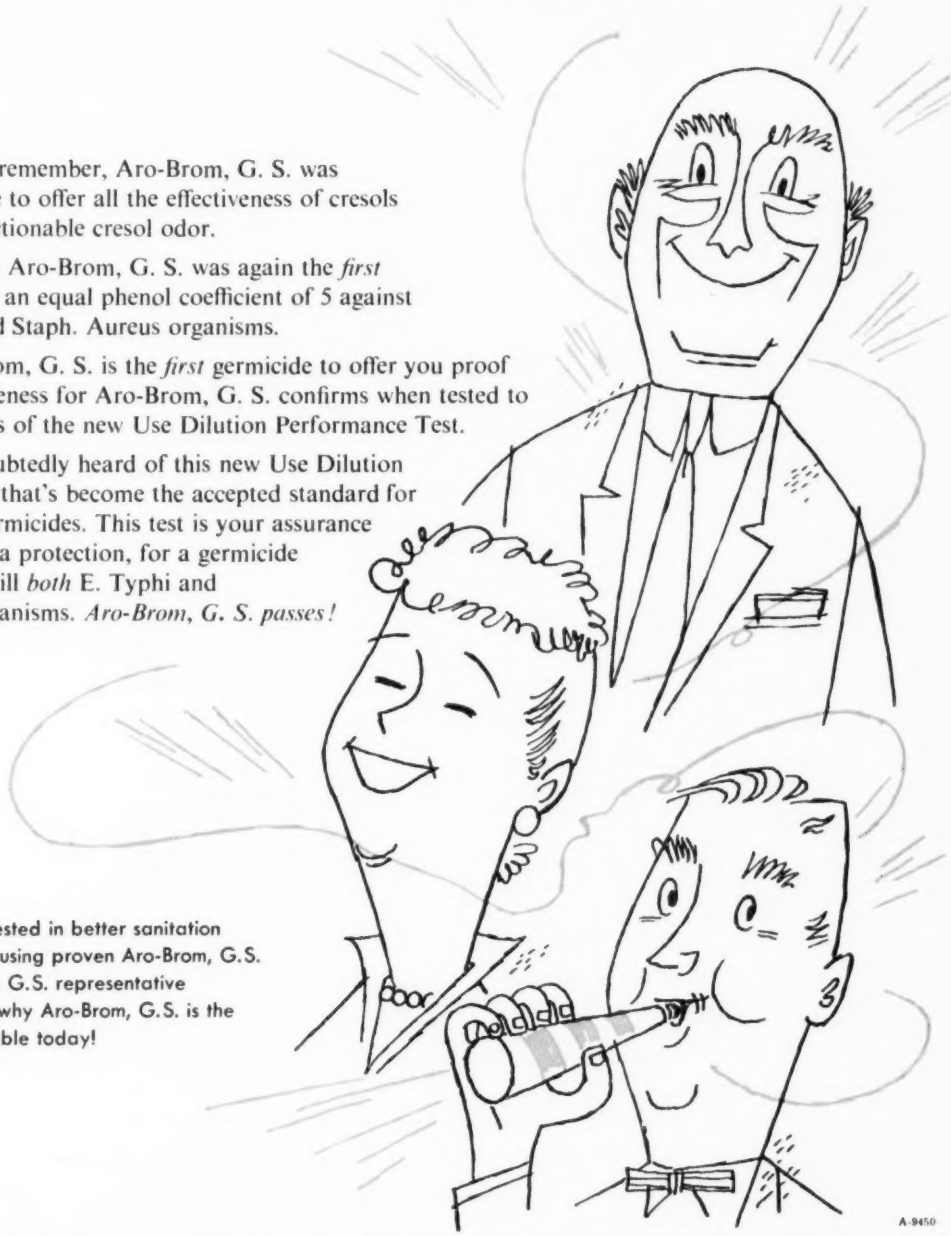

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